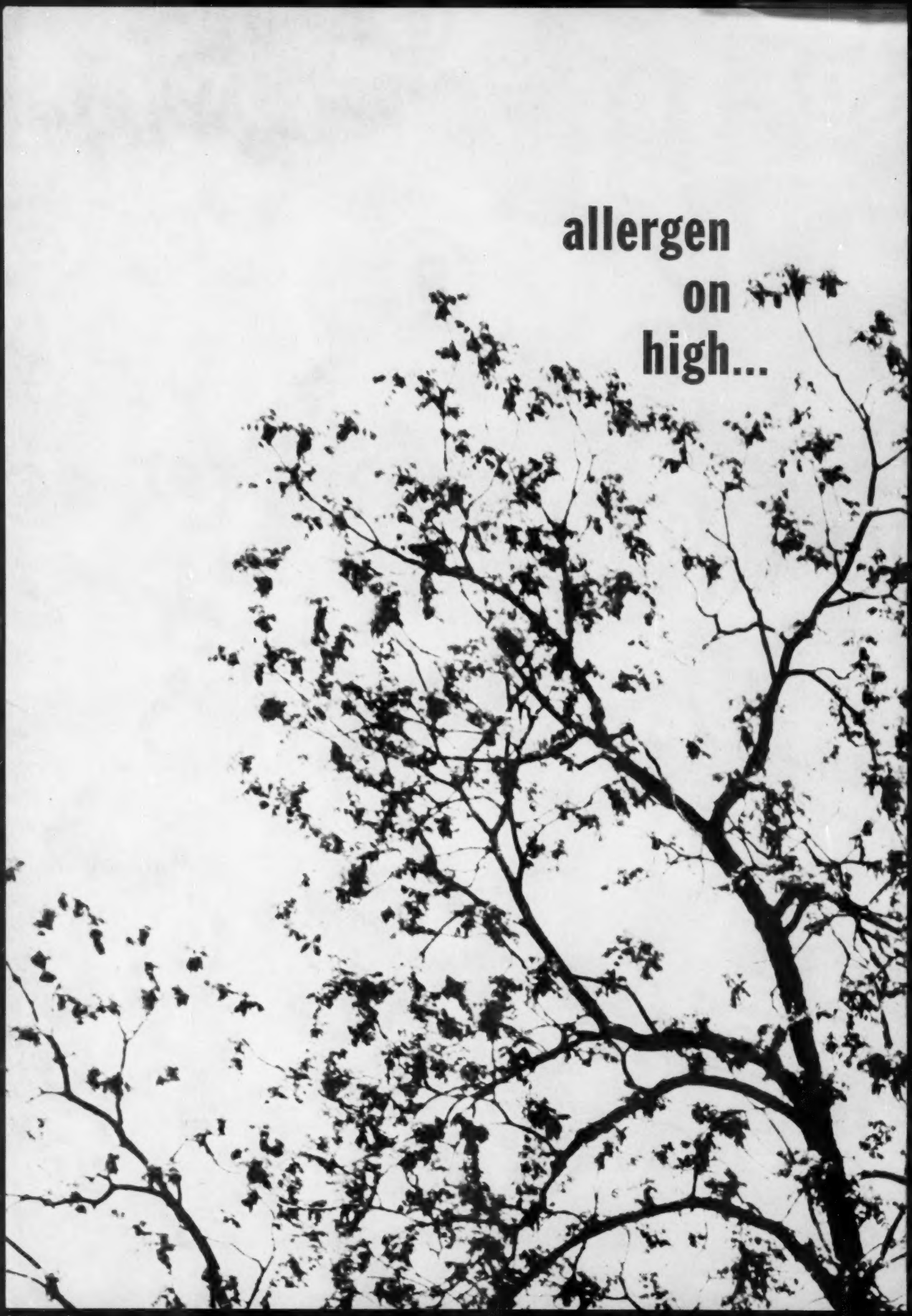
the Journal
MICHIGAN
STATE MEDICAL SOCIETY

JUNE 1960 VOLUME 59 NUMBER 6

MICHIGAN MEDICAL SERVICE

20 Years of Service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IN A "PROBLEM" ARTHRITIC

In disabling rheumatoid arthritis. A 62-year-old printer incapacitated for three years was started on DECADRON, 0.75 mg./day. Has lost no work-time since onset of therapy with DECADRON one year ago. Blood and urine analyses are normal, sedimentation rate dropped from 36 to 7. He is in clinical remission.*

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Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

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the Journal MICHIGAN
STATE MEDICAL SOCIETY

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June, 1960

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2642 University Avenue
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Editor
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

Assistant Editor
L. J. BAILEY, M.D.
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All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 14, Minnesota, or 606 Townsend Street, Lansing 15, Michigan. Telephone IVanhoe 2-1158.

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THE COVER

The JOURNAL each June reports the activities of the Michigan Medical Service, and this year MMS marks its 20th year of service.

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*To fill unexpired term of R. W. Shook, M.D., deceased.

now–for more comprehensive control of *'pain & spasm'*

INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Peliegrini-Stieda disease, tenosynovitis with associated pain and spasm.

–pain due to or associated with –spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin* — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects .... 400 mg.

  *Methocarbamol Robins, U.S. Pat. No. 2770649.

- An analgesic component—aspirin—whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent...... (5 gr.) 325 mg.

INDICATIONS: ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from: I. Allen, Madison, Wisc.; B. Bilter, New York, N. Y.; B. Decker, Richmond, Va.; C. Freeman, Jr., Augusta, Ga.; R. B. Gordon, New York, N. Y.; J. E. Hellerblad, Schenectady, N. Y.; L. Levy, New York, N. Y.; N. Lilker, Chicago Heights, Ill.; H. Nachman, Richmond, Va.; A. Poindexter, Los Angeles, Cal.; B. Rogers, Brooklyn, N. Y.; K. H. Strong, Fairfield, Ia.

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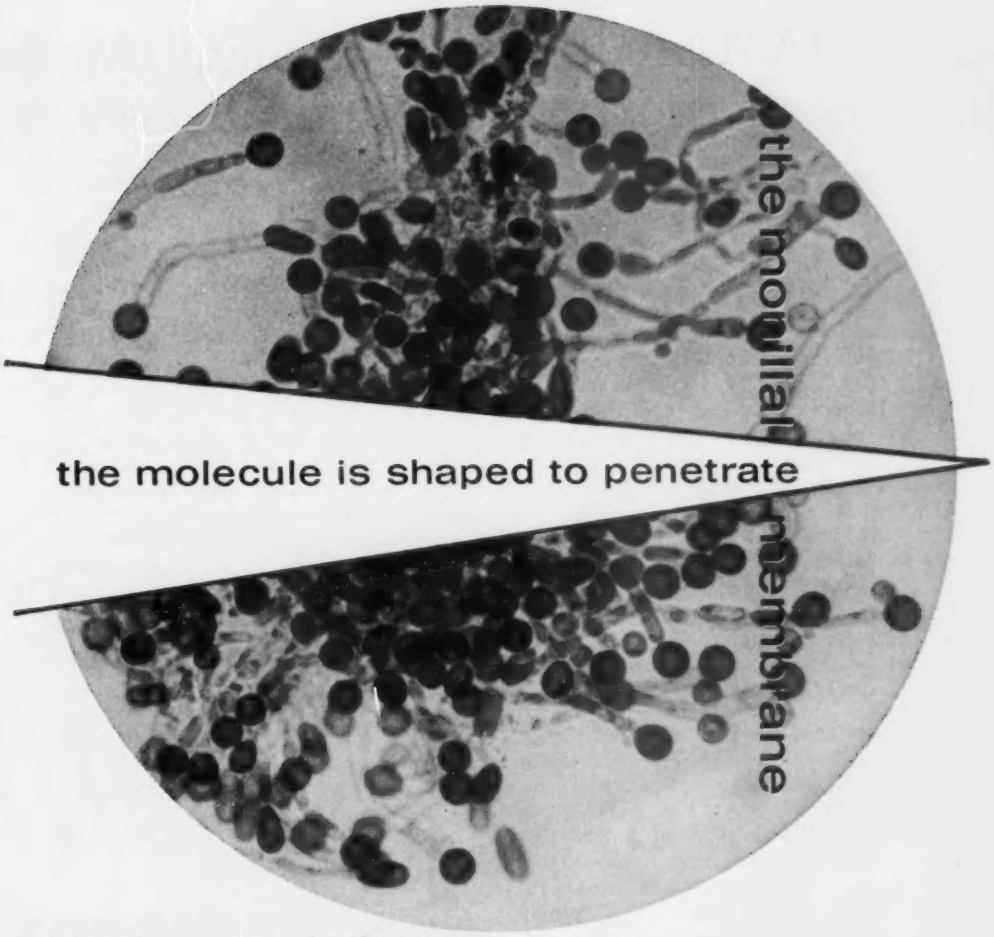


new non-staining SPOROSTACIN® Chlordantoin Cream

chemically different, non-staining, "shaped charge" monilicide
soothing, odorless, white

Exceptional fungicidal activity—The unique "shaped charge" molecular structure of the active agent in SPOROSTACIN Cream facilitates penetration of the fatty barrier of the fungous cell membrane for exceptional fungicidal activity.

Outstanding clinical results—"The use of this new compound, chlordantoin, in the treatment of vaginal candidiasis [moniliasis] offers the advantages of simplicity, patient acceptance, and rapid relief of symptoms, together with a high percentage of culture-free cures."

*Lapan, B.: Am. J. Obst. & Gynec. 78:1320, 1959.

Ortho

Recent JAMA editorial statement clarifies the current controversy about dietary fats

Excerpted from the March 12, 1960, issue of The Journal of The American Medical Association:

"It is accepted generally that specific alteration in the diet will lower the concentration of cholesterol in the blood. The most effective results to date have been achieved by increasing consumption of polyunsaturated fatty acids, particularly linoleic acid. However, indefinitive and conflicting information has left much to the imagination of some food processors. Some of the largest vegetable oil processors in the United States have implied in advertisements that the cholesterol level can be lowered merely by adding polyunsaturated fatty acids to the diet. This selling campaign has created confusion among lay people, making it increasingly important that the physician clarify for his patients the conditions under which changes in the diet will be effective.

The patient should understand that if he increases his consumption of polyunsaturated fatty acids without reducing his intake of other fats, little is gained save for additional calories which could lead to obesity. A particular regimen will be effective only if polyunsaturated fatty acids are responsible for an appreciable percentage of the total fat calories. That is, they must replace rather than supplement some of the saturated fats and oils already in the diet.

* * *

Some manufacturers cite the "iodine number" of a fat or oil as evidence of the unsaturated fatty acid content of their product. This number is not a reliable indicator of therapeutic value because it measures monounsaturated and polyunsaturated fatty-acid content at the same time. A monounsaturated acid, like oleic, takes up two iodine atoms but does not affect the cholesterol concentration of the blood. A polyunsaturated acid, like linoleic, takes up four iodine atoms. In a product containing large amounts of oleic acid and small amounts of linoleic acid, the iodine number is nearly the same as it would be for a product containing little oleic acid and a modest amount of linoleic acid. Cottonseed oil has an iodine number of 110 and corn oil a number of 127; yet they each have about the same amount of linoleic acid.

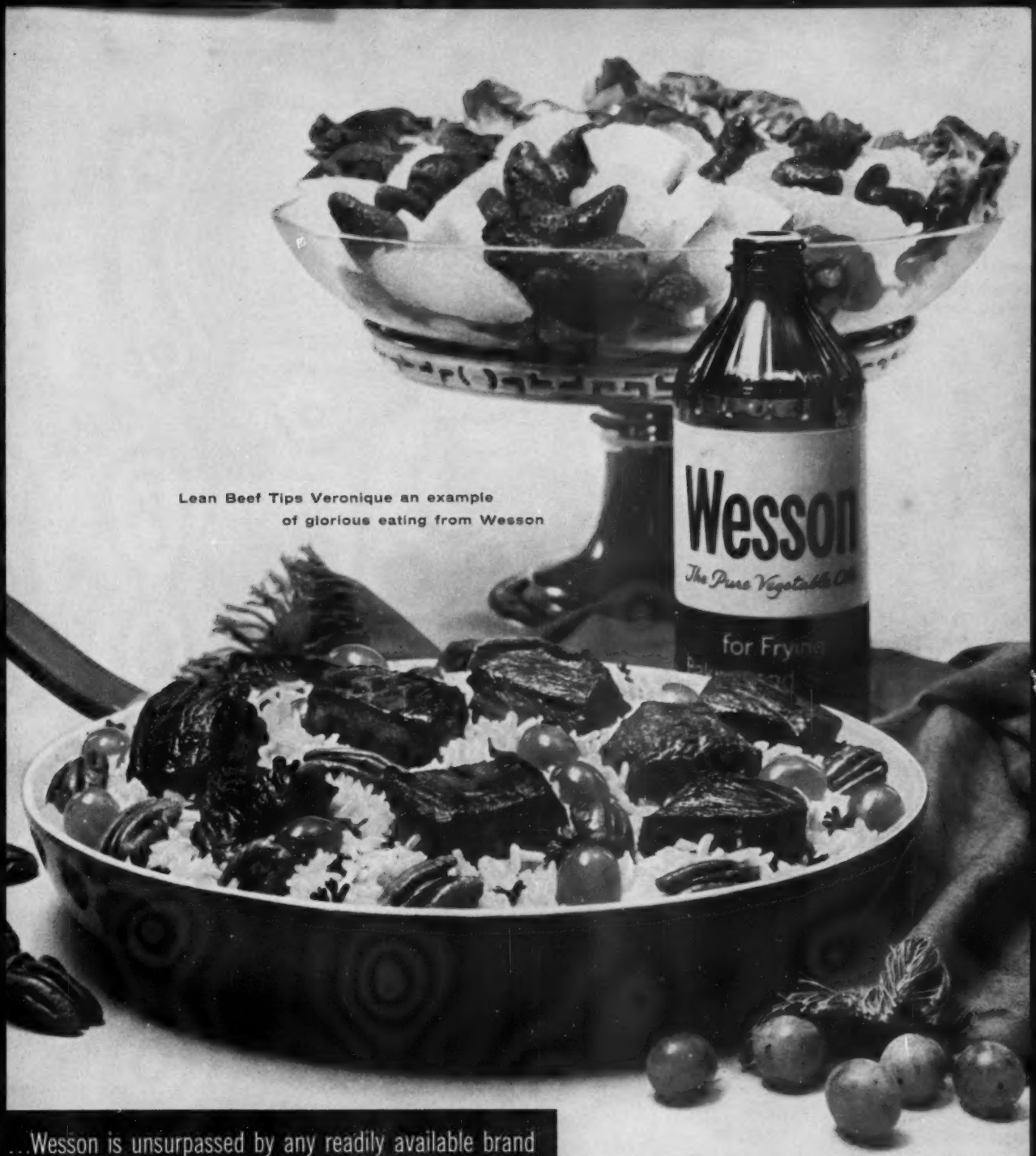
* * *

Low-fat diets will not reduce the concentration of circulating cholesterol and lipoproteins as effectively as will diets containing an adequate percentage of polyunsaturated fatty acids. Weight-reduction regimens are basically low in fat, and if a lowered cholesterol level is necessary, planning must be done to maintain the proper ratio of saturated to unsaturated fats."

* * *

Herbert Pollack, M.D.
Associate Professor of Clinical Medicine
Postgraduate Medical School
New York University, New York

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen



Lean Beef Tips Veronique an example of glorious eating from Wesson

...Wesson is unsurpassed by any readily available brand

WESSON'S IMPORTANT CONSTITUENTS

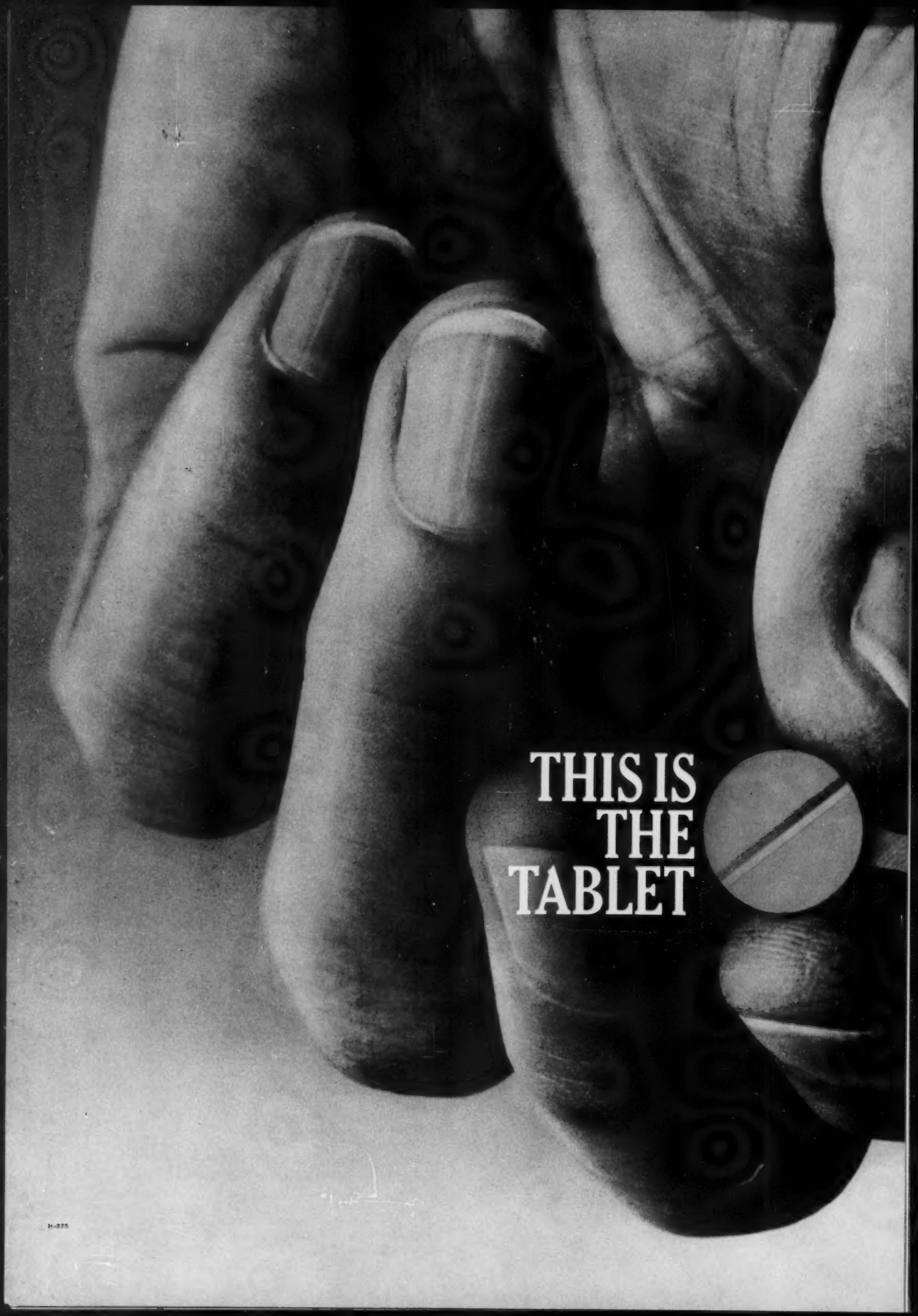
Wesson is 100% cottonseed oil–winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

FREE Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.


THIS IS
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TABLET

ALPEN is the oral penicillin that provides on a fasting stomach peak antibiotic blood levels approximately twice as high as oral potassium penicillin V... and significantly higher than I. M. penicillin G.

Some strains of staphylococci resistant to other penicillins exhibit in vitro sensitivity to potassium phenethicillin.

ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum -mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

HOW TO USE ALPEN Depending on the severity of the infection, 125 mg. (200,000 units) or 250 mg. (400,000 units) three times daily may be used. In more severe or stubborn infections, a dosage of 500 mg. (800,000 units) t.i.d. may be employed. In beta hemolytic streptococcal infections, treatment should be continued for at least ten days.

PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature.

Tablets: 125 mg. and 250 mg., bottles of 25 and 100. Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet that gives higher peak antibiotic blood levels

HIGHER THAN I. M. PENICILLIN G
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ALPEN

ALPEN™—potassium phenethicillin

Schering

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy

As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

"CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

sulfa therapy suited to young tastes and tempers...

Employs the N^1 acetyl form of KYNEX to impart high palatability yet retain single-daily-dose effectiveness and rapid, high sustained action against sulfa-susceptible infections. **Dosage:** first day, 1 tsp. (250 mg) for each 20 lbs.; thereafter, ½ tsp. daily for each 20 lbs. For 80 lbs., use adult dosage of 4 tsp. (1.0 Gm.) initially; and 2 tsp. (0.5 Gm.) thereafter. Taken once a day—preferably after a meal. **Supplied:** Each tsp. (5 cc.) contains 250 mg. sulfamethoxypyridazine activity. Bottles of 4 and 16 fl. oz.

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KYNEX®

N^1 Acetyl Sulfamethoxypyridazine

ACETYL PEDIATRIC SUSPENSION

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Proven

in over five years of clinical use and
more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

- simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
- no cumulative effects, thus no need for difficult dosage readjustments
- does not produce ataxia, change in appetite or libido
- does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- does not impair mental efficiency or normal behavior

for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Generically and under the various brand names by which it is distributed, meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a *known* drug, evaluated in more than 750 published clinical reports. Its few side effects have been fully reported; there are no surprises in store for either the patient or the physician. It can be relied upon to calm anxiety and tension quickly and predictably.

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS®— 400 mg. *unmarked*, coated tablets.

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meprobamate (Wallace)

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CM-2053

when that early Monday morning telephone call is from a weekend do-it-yourselfer

"...and this morning, Doctor, my back is so stiff and sore I can hardly move."

now...there is a way to prompt, dependable relief of back distress

the pain goes while *the muscle relaxes*

POTENT – rapid relief in acute conditions

SAFE – for prolonged use in chronic conditions

notable safety – extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosages

rapid action, sustained effect – starts to act quickly, relief lasts up to 6 hours

easy to use – usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

supplied – as 350 mg., white, coated tablets, bottles of 50; *also available for pediatric use:* 250 mg., orange capsules, bottles of 50

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(CARISOPRODOL WALLACE)

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why Buttermilk is a dietary food!

LOW CALORIES, HIGH ESSENTIAL NUTRITION

One glass, or ½ pint, of plain Buttermilk (uncreamed) contains only 87 calories; a whole quart, only 350. Yet uncreamed buttermilk contains all of whole milk's complete proteins, B vitamins, and minerals. One good dietary reason!

BENEFICIAL BACTERIAL-ENZYME ACTION

For many years Buttermilk has been prescribed as an aid in promoting healthful bacterial balance in the digestive tract, especially the lower tract. Second good dietary reason!

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Making buttermilk sounds simple, but certainly isn't simple at all! Borden's Buttermilk has a deserved reputation for fresh, sweet wholesome flavor.

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or Donnagel® with Neomycin

Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive DONNAGEL formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNAGEL WITH NEOMYCIN

Same formula, plus

Neomycin sulfate	300 mg.

(Equal to neomycin base, 210 mg.)

A. H. ROBINS CO., INC., Richmond 20, Virginia · *Ethical Pharmaceuticals of Merit since 1878*

The first synthetic penicillin available for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICATED .

SYNC

PEAK BLOOD LEVELS HIGHER THAN POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER INITIAL PEAK BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY

SUPPLY: SYNCILLIN TABLETS–250 mg. and SYNCILLIN TABLETS–125 mg.
SYNCILLIN FOR ORAL SOLUTION–60 ml. bottles–when reconstituted, 125 mg. per 5 ml.
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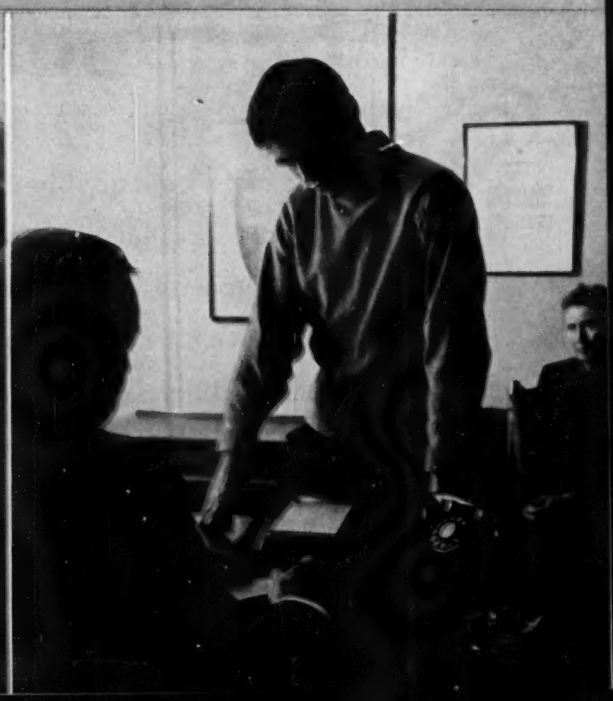

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potassium phenethicillin (POTASSIUM PENICILLIN-152)

ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE

SOME STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

BRISTOL LABORATORIES, SYRACUSE, NEW YORK (BRISTOL)

President's Page

THREE IMAGES

Milton A. Darling

President

Michigan State Medical Society

Recently a metropolitan newspaper commented upon the public's image of the doctor. It pointed out that "just as the earlier image of the doctor (dispensing medicine and good advice in his office, bringing reassurance to an anxious household at a grim hour of night) has been romanticized, so today's caricature of an impersonal healing machine with a built-in cash register is distorted beyond reality."

Perhaps the newspaper was right and today's image is such. But it is equally possible that we are dealing with not one but three images existent in the public mind:

1. Medicine: Viewed by the people as an entity in itself. A highly advanced entity of which, if they get enough, and at the right time, all pains can be overcome and death can be deferred.

2. The individual Doctor of Medicine: Considered by the public generally to be a reasonably nice guy who has been well-trained, talks mainly to other doctors about medicine, is "opinionated" when he talks about subjects other than medicine, and makes a "lot of money."

3. The Medical Profession: The polite name the public uses for the doctor's union epitomized by the AMA—to them a powerful lobby group that needs better public relations.

Split into these three images, it's not so good. But we wouldn't fare too badly PR-wise if we merged these three images into a single image and added one indelible gravure—our primary desire to serve the people in the public interest.

Merged, these could evolve into a single image of a group of nice, well-trained, prosperous, civic-minded people who are controlling a valuable, constantly improving commodity, and protecting its application, so that the public can be better served.

That's a pretty good image.

* * *

WE CAN HAVE THAT IMAGE if each of us, jointly, works as hard to deserve and gain it as do some of our detractors and the socializers who work to divide us.

Medicine—the Doctor of Medicine—and the Medical Profession are one and the same.

Somebody said our public image is our shadow cast in bold relief by the light of public opinion against the background of modern society.

* * *

LET'S BE SURE THAT, individually and collectively, we do our part to keep the light of public opinion white and in steady focus so that our shadow is our true image. Above all, don't buy the bunk that we can escape the light. We're too valuable a part of today's civilization to do that.

This adds up to the fact that we must communicate. To repeat: communication is carried out best by the doctor in his office through his word and *deed*.

We've got a job to do. Right now.

State Society Testifies At Insurance Hearings

The support of the Michigan State Medical Society for the requested increase in Michigan Medical Service premiums was voiced at two public hearings held in May by the Insurance Commissioner of Michigan.

"The public interest can best be served by the increase in premium rates requested," stated H. J. Meier, M.D., Chairman of The MSMS Council, at the Detroit hearing. "We are confident that the Insurance Commissioner will find that the new premium rate structure offered by Michigan Medical Service is fair and just," he added.

Doctor Meier explained that premium rates were based upon the previous utilization experience of Blue Shield and projected to cover the new services. These estimates of the premium were too low because utilization of the services increased. More people needed more services than anticipated. Consequently, it is necessary that additional income be obtained by Michigan Medical Service in order to continue to offer the services of Blue Shield."

Doctor Meier added:

* * *

"WE KNOW THAT THE management of Michigan Medical Service has been carried out on an efficient and economical basis.

"We believe that the fees for services paid by Blue Shield are not excessive and that no decrease in payments for individual services to doctors is fair or warranted.

"We believe that the subscribers want and need the services of Michigan Medical Service contracts and are on the whole willing to pay the amount necessary to receive Blue Shield protection.

"We believe that the public is not informed as to the amount that they are paying for these services and are confusing these payments with amounts paid for other services. Only about one-third of their total health care premium goes for medical and surgical services.

"We contend that in the final analysis, it is the public itself which will determine what the premium rate must be, since that rate is based on desired benefits and utilization."

Doctor Meier, J. W. Rice, M.D., chairman of the MSMS Medical Care Insurance Committee, and Donald N. Sweeny, Jr., M.D., of Detroit, who is chairman of the prepaid medical care plans committee of the Wayne County Medical Society, represented the State Society at the hearings. They had been authorized by The MSMS Council.

At Detroit, Doctor Meier read the official statement and Doctor Sweeny, in response to questions raised by other testifiers, described grievance and mediation procedures in operation by the medical profession.

At Grand Rapids, Doctor Rice read a new MSMS statement and Doctor Meier described activities of MSMS in meeting challenges posed by the aged.

THE HEARINGS FOLLOWED A similar pattern. At both Detroit and Grand Rapids, the sessions opened with statements by G. Thomas McKean, M.D., president of Michigan Medical Service, and L. Gordon Goodrich, executive vice-president of MMS. They were followed by Doctor Meier at Detroit and Doctor Rice at Grand Rapids.

Then Michigan Insurance Commissioner Frank Blackford called upon organized groups to present their statements. At both hearings, officials of organized labor opposed the request for the 19½ per cent rate increases. At both hearings, individuals in the audience were permitted the opportunity to make statements and to ask questions.

Some of the questions raised at Detroit by labor representatives and by spokesmen for retired workers were answered in the statement of Doctor Rice at Grand Rapids.

In part, Doctor Rice said:

* * *

"WE ARE CONSIDERING TODAY the basic problem of utilization of services under Blue Shield contracts because this utilization determines the total cost of executing these contracts. There seems to be, even in the minds of those opposing Blue Shield, no doubt that the fees paid to the doctors are fair and reasonable. In view of inflationary costs for physicians' overhead, it could well be said that fees paid by Michigan Medical Service are less than they should be. This is indicated by the fact that whereas in 1938 the physician's fee approximated 31 per cent of the dollar spent for medical care, today the physician's fee represents but 24 per cent of the same dollar. It is a recognized fact that physicians' fees have not increased at a pace comparable with the cost of living index or the cost for other health services.

"It is important to remember that the Blue Shield Plan is a service plan and that only doctors can guarantee their own services. These have been guaranteed through the efforts of the Michigan State Medical Society. At the present time, 80 per cent of the members of the Michigan State Medical Society have agreed to accept the fees paid by Michigan Medical Service as full payment for services rendered under the Michigan Medical Service contracts.

"It is a not-too-well-known fact that of all services rendered to the public, medical services are subject to closest scrutiny and review. Every approved hospital in which these services are rendered has medical audit and tissue committees which review surgery performed and hospital length of stay of all persons receiving care. Blue Shield's continual review of payments reveals any deviations from the number of services normally rendered.

"Despite these protections, it is still possible for misunderstandings to occur between the physician and his patient; therefore, in order that the public may be assured that it has recourse of any question which may arise, the Michigan State Medical Society and each of its 55 component county and district medical societies covering the entire state have established ethics committees, grievance and mediation committees, medical care insurance committees and other state medical society machinery for appeal, to which the patient may go to adjudicate any problem arising in his relationship with the doctor.

* * *

"IN VIEW OF THE RISING number of services performed under the Blue Shield contract, it is difficult to believe that there has been any great scarcity of doctors to render these services. As a matter of fact, it was through the efforts of the medical profession that the supply of doctors in Michigan has increased by nearly one-third in the last twenty years. The Michigan State Medical Society successfully urged the Legislature to increase the teaching facilities and personnel of both the University of Michigan Medical School and Wayne State University College of Medicine. Today the University of Michigan is one of the largest medical schools in the world in number of graduates, and Wayne State's medical school has increased its freshman class by 67 per cent. Here again, the policy of the State Medical Society to help increase the number of doctors in Michigan is clearly evidenced.

"Charges have been made that doctors have increased their fees because the patients had insurance coverage. We have investigated every such charge brought to our attention. The misunderstanding that such increased charges have been made has been based upon the fact that if the patient has an income higher than $7,500 or where the patient has abrogated other terms of his contract, the doctor is entitled to the privilege of charging an equalizing fee. That fee may be commensurate with what that doctor would normally charge if the patient were not insured by Blue Shield. In other words, as is the case with many insurance policies, the policy holder does not understand the limits of his coverage even though these limits may be generous."

MSMS annually provides thousands of medical facts to thousands of people in hundreds of meetings.

HIGHLIGHTS of MSMS Council Meeting

Meeting of April 13, 1960

At this meeting, held in Grand Rapids, sixty-nine items were presented to The Council. Chief in importance were:

- Recommendations of Council Chairman H. J. Meier, M.D., to aid communication between The Council and the MSMS membership and to increase efficiency and conduct of Council meetings. The Council endorsed in principle three of the four recommendations of the Chairman, and commended Doctor Meier for his detailed study and his recommendations to improve liaison and communication within the Michigan State Medical Society.

- Report on 1960 Michigan Clinical Institute. Executive Director Burns reported on the excellent scientific program and a total attendance of 2,671 including 1,261 doctors of medicine. The Council recommended to the 1961 MCI Committee on Arrangements that the Institute next year begin on Wednesday morning and end Friday at 1:00 p.m. A Committee of The Council was authorized to develop recommendations for improving this refresher course through use of more closed circuit television (including wet clinics), scientific panel discussion in depth, inc.

  Milton A. Darling, M.D., Detroit, was appointed Chairman of the 1961 MCI Committee on Arrangements.

- Student AMA. Request for financial assistance to send a delegate and an alternate from each of the two SAMA units in Michigan was approved by The Council.

- MSMS Workshop on Aging at Kellogg Center, April 3. A report on this meeting was reviewed by The Council and detailed discussion was given to the ten suggestions emanating from the Conference, which were approved with instruction that they be implemented and activated wherever possible. Report of this Workshop had been transmitted to program participants, county society officers, MSMS Councilors, members of the MSMS House of Delegates, and AMA Delegates and Alternates from Michigan.

- President Milton A. Darling, M.D. reported that Paul Dudley White, M.D., Boston, will be Biddle Lecturer at the 1960 MSMS Annual Session in Detroit.

- The House of Delegates Press Committee and the Scientific Press Committee for the 1960 MSMS Annual Session were appointed.

- Report was given on "Kellogg Center Health Conference" held April 1-2-3, in East Lansing, called by G. Mennen Williams to develop a liberal health program for possible use by the national Democratic party. In discussion of policy of the Michigan State Medical Society regarding solutions to the health needs of the aged, the following motion was adopted: "That the stated policies of the Michigan State Medical Society, including the ten suggestions emanating from the MSMS April 3 Workshop on Aging, be referred to the MSMS Public Relations Committee for communication to MSMS members and to the public, and that the component societies be asked for their advice and suggestions regarding these items."

- President Elect K. H. Johnson, M.D., presented monthly progress report on the erection of the new MSMS headquarters building.

- MSMS History Questionnaires. It was reported that 4,507 MSMS members have returned their questionnaires.

- The annual reception in honor of members of Michigan Health Officers Association was authorized; this will be held at the Pick-Fort Shelby Hotel, Detroit, on May 11. The Officers and Councilors in the southeastern area of Michigan were requested to act as hosts.

- Legal Counsel's Report. Lester P. Dodd, LL.B. presented correspondence from the Michigan Board of Pharmacy re proposed rule for use of generic name drugs in lieu of brand names with permission of the physician—which matter was deferred to the May 18 Council meeting, in order to gain further information from various interested groups and individuals.

- MSMS plan for retirement trust if the Keogh bill (HR 10) becomes law: the Council Chairman was authorized to appoint a Council Committee on Retirement Trust Plans to study and prepare a suitable plan for offer to MSMS members providing HR 10 is enacted. The Committee personnel: W. M. LeFevre, M.D., Muskegon, Chairman, H. H. Hiscock, M.D., Flint, G. B. Saltonstall, M.D., Charlevoix, D. Bruce Wiley, M.D., Utica, and Legal Counsel Lester P. Dodd, Detroit.

  The Council urged that members be warned of the possible flooding of their mail with retirement trust plan offers, upon passage of HR 10, and that Michigan physicians be advised that the MSMS is developing a sound plan for their consideration. 1. Two improvements in the MSMS group life con-

tract were presented by Mr. Dodd: (a) The policy is altered so that those not in active practice at the time the policy was inaugurated can be paid benefits until April 1, 1959; and (b) the definition of membership is altered so that those who retire before age 70 may continue with the policy until age 70. The necessary papers to include these two improvements in the MSMS group life contract were authorized to be signed by the Secretary. 2. Correspondence from Wayne County Medical Society regarding report on Peoples' Community Hospital Authority situation in the Wayne-Washtenaw area, was referred to President Darling and Legal Counsel Dodd who were authorized to prepare a letter setting forth the legal problems involved in connection with the activities of the Authority.

- Financial Report. The monthly financial report, including a comparison of expenditures versus budget for the first four months of the Society year, was presented by Finance Chairman O. B. McGillicuddy, M.D. Bills payable were presented, approved, and payment was authorized.

- The Wayne County Medical Society was invited to collaborate in the selection of the MSMS field secretary who is to be based in Detroit, and his duties are to be confined mainly to Wayne, Macomb, and Oakland Counties.

- Public Relations Counsel H. W. Brenneman reported on legislation, both Federal and State; plans for the Michigan State Fair exhibit which were approved by The Council; plans for the annual Congressional breakfast in Washington, D. C., May 2-3; on Regional White House Conferences on Aging in various parts of Michigan; and on the advisability of recommending M.D. delegates to the National White House Conference on Aging (January 1961) for submission to Governor Williams; and on the Oakland County Medical Society Awards to radio station WPON and to the Pontiac Press.

- Committee reports: (a) Advisory Committee to Executive Director, meeting of April 13, reported on twelve items discussed. The motion of The Council was: "That The Council commends the Executive Office staff which is working diligently and harmoniously to carry out the instructions of the House of Delegates and of The Council and the purposes of the Society." (b) CDMCIC members—length of terms: the action of The Council was "that the Councilor District Medical Care Insurance Committees shall be reappointed each year, and that not more than two-thirds of each committee shall be new members." (c) Progress report on Michigan Relative Value Study was presented by Luther R. Leader, M.D., Chairman, whose written report stated that the results of the questionnaire survey had been tabulated on IBM cards and that conferences with specialty groups are being scheduled in April and May, every weekend. Doctor Leader was invited to present a verbal report to The Council on May 18. (d) Report from L. W. Gardner, M.D., Detroit, on meeting of Board of Directors of North Central District Blood Bank Clearing House, held March 11 in Chicago, was received with thanks. (e) Report from C. P. Anderson, M.D., Detroit, on meeting of AMA Council's Committee on Disaster Medical Care, held in Chicago, was received with thanks.

- Appointments: (a) The Council Chairman was authorized to appoint a representative to the Michigan State Nurses Association Committee on Nursing in National Defense. (b) The Council Chairman was authorized to appoint representatives to the Michigan Advisory Committee on Psychiatric Nursing of the Michigan State Nurses Association: I. A. LaCore, M.D., Pontiac, Wm. A. Scott, M.D., Kalamazoo. (c) MSMS representatives to the University of Michigan Conference on Aging, Ann Arbor, June 27-29, were selected: A. H. Hirschfeld, M.D., Detroit, H. J. Meier, M.D., Coldwater, A. Hazen Price, M.D., Detroit, F. C. Swartz, M.D., Lansing, R. W. Teed, M.D., Ann Arbor, and H. B. Zemmer, M.D., Lapeer. (d) The Council Chairman appointed the personnel of the Advisory Committee on Vocational Rehabilitation: S. D. Steiner, M.D., Detroit, Chairman, S. E. Andrews, M.D., Kalamazoo, C. W. Sellers, M.D., Detroit, J. W. Rae, M.D., Ann Arbor, and Harvey Hansen, M.D., Battle Creek. (e) Glen E. Millard, M.D., Detroit, was appointed as Vice Chairman of the MSMS Advisory Committee to the Michigan State Medical Assistants Society.

Hospital Services and Costs

More people are entering hospitals now than ever before because more are going to physicians, and physicians are caring for many of these patients in the hospital—where equipment, supplies, and trained teams of workers are centered to aid in diagnosis and treatment and to speed recovery.

There is now an average of 2.2 hospital employees for each patient treated in a general hospital, compared with 1.5 in 1946. Nearly two-thirds of these employees work in the professional service departments, such as nursing service, operating and delivery rooms, x-ray, laboratories, and pharmacy. The others work in the operation and maintenance, food service, and administrative areas.

Payroll accounts for two-thirds of total hospital costs, compared to one-third for industry. But unlike industry, the hospital must be ready to function 24 hours a day, 365 days a year. And the hospital cannot automate, except behind the scenes. Direct patient care is a personal service, to meet the individual human need.

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THE REALMS OF THERAPY BEST ATTAINED WITH

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World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
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Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. 10:164, 1956. Ayd, F. J., Jr.: California Med. 87:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. 112:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

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INJECTION

Kanamycin Sulfate Injection

...a highly potent, bactericidal antibiotic for combating staph and gram negative infections

...well tolerated when used on a properly individualized dosage schedule which does not induce excessive blood levels

"In many instances its effect has been dramatic and life saving..."[1]

"Six of the patients who survived were considered to be terminally ill at the time kanamycin was started but showed dramatic improvement and eventual complete recovery."[2]

"...indeed, the results [with kanamycin] are the most remarkable ever achieved with otherwise fatal staphylococcal infections that we have ever seen."[3]

"There appears to be no doubt that kanamycin has been lifesaving in those instances in which organismal resistance precludes the use of other antimicrobials."[4]

Information on dosage, administration and precautions contained in package insert or available on request.

SUPPLY: KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in vial containing 2 ml. volume. KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in vial containing 3 ml. volume.

REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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6-10 HOURS
SUSTAINED THERAPY

ONE *and only* ONE
Timed AMO*dex* CAPSULE
PER DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
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AMO*dex* ADVANTAGES

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PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

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Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
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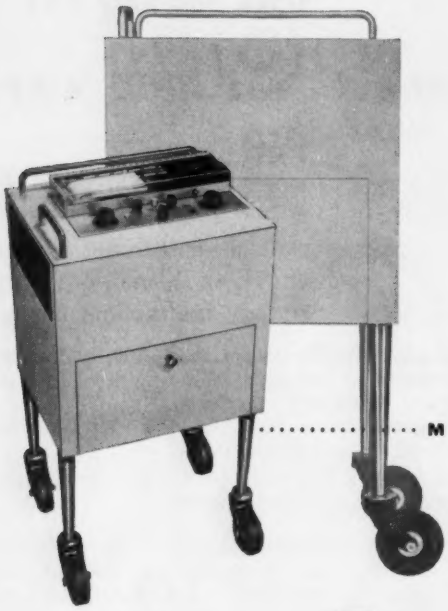

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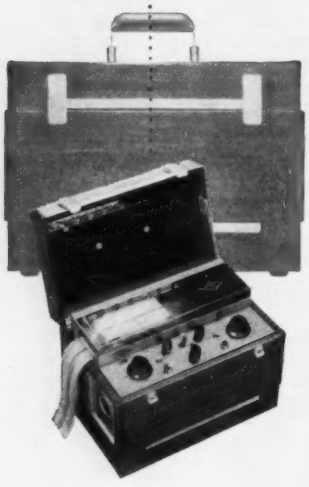

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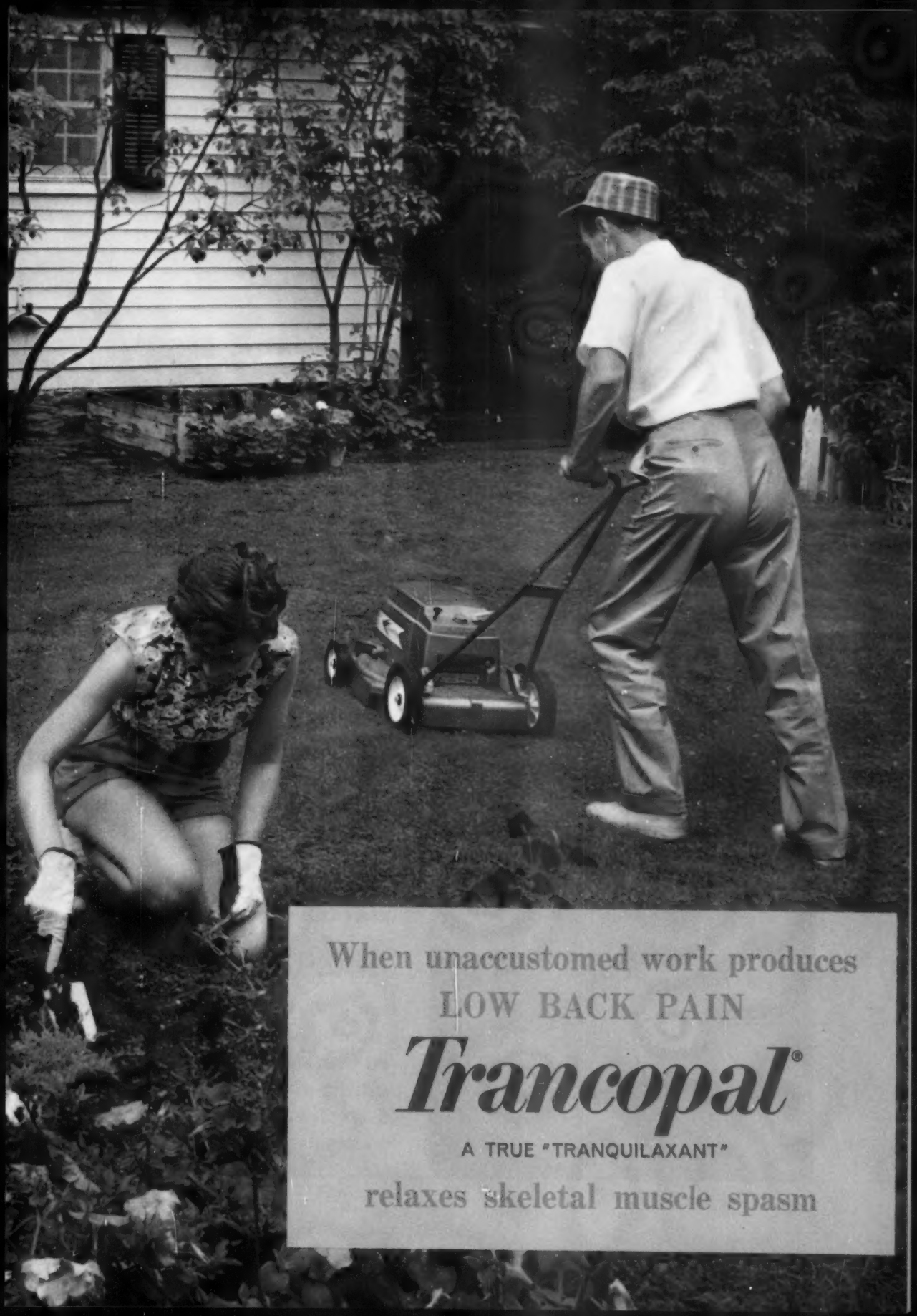
When unaccustomed work produces
LOW BACK PAIN
Trancopal®
A TRUE "TRANQUILAXANT"
relaxes skeletal muscle spasm

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the pain
and disability
of
musculoskeletal
disorders

When enthusiastic gardening – or any of a host of other pleasant summer activities – brings on low back pain associated with skeletal muscle spasm, your patient need not be disabled or even uncomfortable for any length of time. The spasm can be relaxed with Trancopal, and relief of pain and disability follows promptly. The patient can usually continue his normal activities while taking Trancopal.

Lichtman[1,2] used Trancopal to treat patients with low back pain, stiff neck, bursitis, rheumatoid arthritis, osteoarthritis, trauma and postoperative muscle spasm. He noted that Trancopal brought satisfactory relief to 817 of 879 patients (excellent in 268, good in 448, fair in 101). "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[1]

Gruenberg[3] also prescribed Trancopal for 70 patients with low back pain and observed that it brought marked improvement to all of them. "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."[3] In another series of 193 patients Kearney[4] obtained relief with Trancopal in 181 patients suffering from low back pain and other forms of musculoskeletal spasm.

Trancopal enables the anxious patient to work or play. According to Gruenberg, "In addition to relieving muscle spasm in a variety of musculoskeletal and neurologic conditions, Trancopal also exerts a marked tranquilizing action in anxiety and tension states."[3] Lichtman[1] found that his patients in anxiety and tension states ". . . were in many instances able to continue their normal activities where previously they had been considerably restricted in their activities."[1] ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available." (Kearney)[4]

Side effects are rare and mild. "Trancopal is exceptionally safe for clinical use."[3] In the 70 patients with low back pain treated by Gruenberg,[3] the only side effect noted was a mild nausea which occurred in 2 patients. In Lichtman's group, "No patient discontinued chlormethazanone [Trancopal] because of intolerance."[1]

A TRUE "TRANQUILAXANT"

Trancopal

potent muscle relaxant

effective tranquilizer

- In musculoskeletal disorders, effective in 91 per cent of patients.[5]
- In anxiety and tension states, effective in 89 per cent of patients.[5]
- Low incidence of side effects (2.3 per cent of patients).
  Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
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Indications:

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Neck pain (torticollis)
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Fibrositis
Myositis
Ankle sprain, tennis elbow
Osteoarthritis
Rheumatoid arthritis
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Postoperative muscle spasm

Psychogenic disorders
Dysmenorrhea
Premenstrual tension
Anxiety and tension states
Asthma
Angina pectoris
Alcoholism

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200 mg. (green colored, scored), bottles of 100.

100 mg. (peach colored, scored), bottles of 100.

Dosage: Adults, 200 or 100 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

References: 1. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958 • 2. Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Jan. 4-7, 1959, Miami Beach, Fla. • 3. Gruenberg, F.: *Current Therap. Res.* 2:1, Jan., 1960 • 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960 • 5. Collective Study, Department of Medical Research, Winthrop Laboratories.

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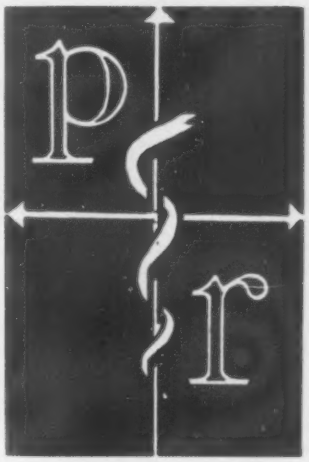
Explains MSMS Presidential Program

At the County Secretaries-Public Relations Seminar, President Darling, in conjunction with President-Elect Kenneth H. Johnson, announced a new five-year MSMS program. Here is a review of Doctor Johnson's remarks delivered on January 31, 1960, in Detroit. A review of Dr. Darling's speech appeared in the April number of THE JOURNAL.



Pioneers of the Future

By Kenneth H. Johnson, M.D., President-Elect
Michigan State Medical Society

The Michigan State Medical Society is ninety-five this year, 1960.

The significance of this lies not in the number, but in the fact that its members have been continuously engaged during this period in efforts to bring good medical care and the finest service possible to the citizens of this State.

Through extensive programs in post-graduate medicine, it has provided the means for all of its 6000 members to avail themselves of up-to-the-minute information in scientific medicine. Through its various committees it has been active in a variety of problems in preventive medicine, public health, mental health, geriatrics, veterans programs, as well as many others. Its concern in the fields of sociological and economic progress are reflected in a strong public relations program with extensive facilities for education to the public; by the development of a program for prepayment of medical care costs; by continuing efforts to secure more information through documentation of public opinion in these problems.

While its members are particularly noticeable by their absence in the field of politics, the Society has maintained an active committee and lent much assistance in efforts to provide factual information to those whose duty it is to legislate.

No Time to Rest

It might be justifiable for the MSMS to rest on its laurels, to point with pride, to be satisfied with the present status. However, it seems that this would be ignoring a great challenge which is presently before our Society. One needs only to follow the daily reports from various news agencies to realize that there are many destructive forces at work in today's world.

A strongly unified, carefully worked out program aimed at holding together the ideals which remain basic in our human family might do much to counteract those forces which tend to split us apart. Our efforts would not be as dramatic as will be those which eventually change the destructive force of the atom to peaceful work, but in the field of human relationships in this State such a program could result in a terrific stimulus toward the "better life."

Thus, in the history of our Society we stand at a most challenging time when next September, we dedicate a new headquarters building for the Michigan State Medical Society.

It will be a beautiful building symbolizing the inherent dignity

and respectful pride of Michigan Medicine The architectural attractiveness of this building will speak for itself but there is a far more potent functional attribute being built into our new headquarters. It has been designed to reflect the idealistic purpose and constructive activity of the Michigan State Medical Society. This was not by mere chance. We intend that this structure shall not be a mausoleum of the past nor a monument to the present, but it shall represent a working and workable function of the future.

Five-year Project

The Council of the M.S.M.S has approved a project whereby the Society will undertake to lead all interested parties in achieving a goal for all the citizens of this State. It has been suggested that this be called "The President's Program" since it is hoped that we may enlist the aid of others at the top level of organizational activity. Very briefly, the project proposes that starting in 1960 with the 95th year of the existence of the State Society and with a functional new building—we will use the next five years, culminating in our 100th anniversary in 1965, to increase life expectancy in Michigan by five more "good" years.

It is most important that we understand that this project is not specifically contemplating adding five years onto the end of the present life span of the inhabitants of the State. What is proposed is that we attempt by a concerted effort, to increase the "good" years of life by five for any or all age groups.

If we use as an example, our perinatal mortality problem and strenuously try to improve it, it is easy to visualize that we have a golden chance to accomplish a tremendous purpose in this one field alone. There are other areas just as significant.

We in the State Society already have the set-up to do this job with little increase in expense to us. We already have the organizational structure to do it. It is a natural, for us. All we need to do is to intensify our efforts, and to coordinate our thinking and activity towards a common goal for the next five years.

There is no question that we shall have the complete cooperation of the Michigan Department of Health. Dr. Heustis, the Commissioner, has already given enthusiastic approval of the idea. We shall have the help of other groups already absorbed in a variety of efforts in this broad field and having a direct relationship to the State Society.

To Enlist All

We propose additionally to enlist the aid of industry, labor, social groups, service organizations, and any other group or individual who is concerned with the best chance for good health and for a happy life for every citizen of this State.

I am sure you understand that this program cannot be implemented until it has been approved by the House of Delegates next September. There is much that must be done in the way of ground work, before we can present the idea to the House of Delegates. We must spell out the details so that the House may evaluate it properly. Thus we hope to secure—

1—The enthusiastic support of each County Medical Society.
2—Make immediate contact with those committees most concerned with this project within the organization of the State Society.
3—Discuss with our professional associates this project.
4—Contact other organizations and individuals to enlist their enthusiastic support.
5—Ascertain what specific support may be obtained in the way of money or services or both.
6—Arrange meetings between our Project Committee and the Presidents of other organizations.
7—Pull all the facts together and spell out a plan to present to the House next September.

We believe this idea will work. We trust in having the enthusiastic support of the entire profession in this united effort toward our always basic goal—the alleviation of suffering and the saving of human life.

Honor Science Fair Winners

In March, the Saginaw County Medical Society honored 20 school pupils having the top exhibits pertaining to medicine entered in the Saginaw County Science Fair. The pupils were guests of the Society at a luncheon at the Bancroft Hotel where they were presented certificates by Society officials.

In Lansing, the Ingham County Medical Society presented the two top Grand Award winners in the junior science fair with $25 savings bonds and each received an engraved plaque.

Two medical-science division winners in Midland received awards from the Midland County Medical Society following the annual Midland Science Fair held in April.

MSMS Members Spoke to Many Service Clubs During MCI

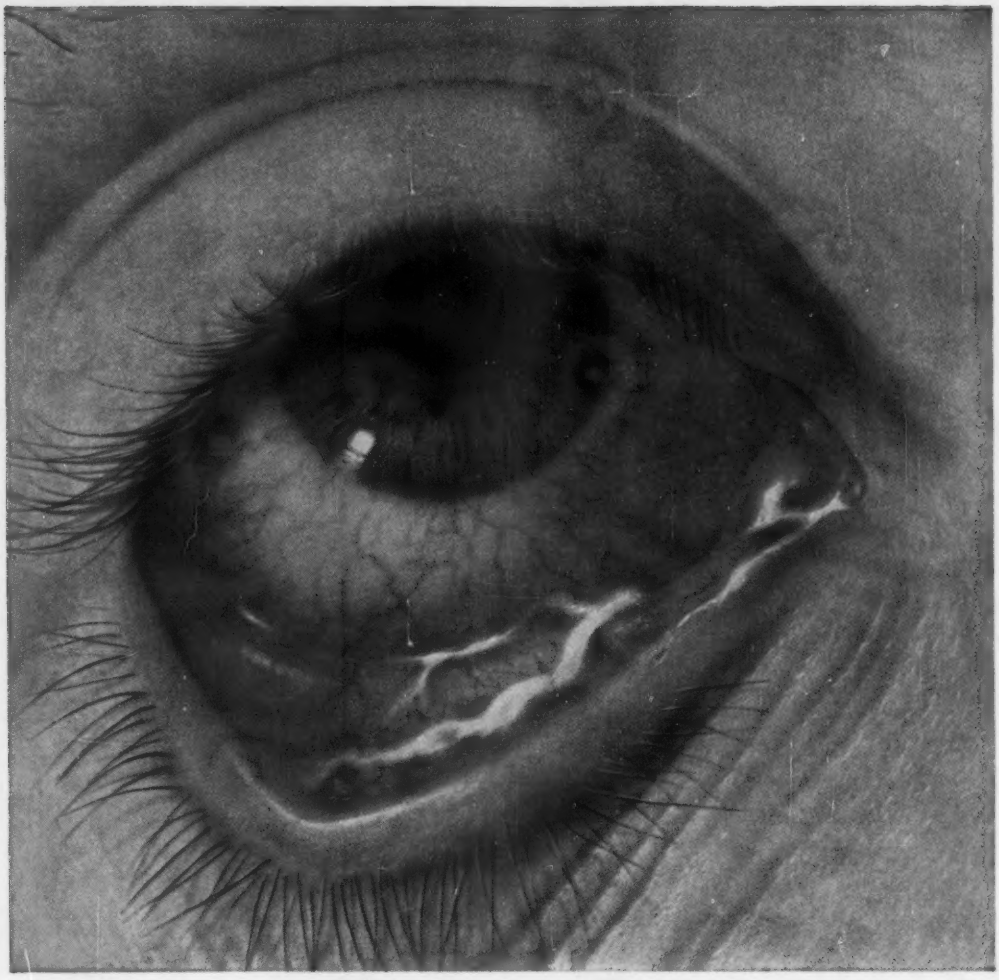
Once again, the 1960 Michigan Clinical Institute provided the opportunity for many MSMS members to appear as guests speakers for meetings of the Detroit metropolitan area service clubs. Several photos are presented here; the complete report of the project appeared in the May number of THE JOURNAL.

A. H. Hirschfeld, M.D. *(right)*, Detroit, addressed the meeting of the Detroit Kiwanis Club No. 1. Also shown at the speakers table are John E. Wells *(left)*, program chairman, and Frank Gofrank *(center)*, club president.

"The main burden of any public relations program necessarily falls on the individual members and they must recognize that a good reputation has to be deserved and earned." —THOMAS G. HIGGINS, president of the New York State Society of Certified Public Accountants.

C. Howard Ross, M.D. *(center)*, of Ann Arbor, spoke about geriatrics at the meeting of the Excalibur Club. F. W. Miller *(right)*, club program chairman, pins a "guest" badge on Doctor Ross while Wallace MacHesney *(left)*, club president, watches.

C. J. Hipps, M.D. *(right)*, Detroit, used slides to help illustrate his address to the Civitan Club. Shown with him is John Chase, club vice president.



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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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Manufacturers to Study Use and Cost of Drugs

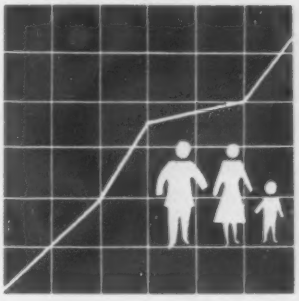
The Pharmaceutical Manufacturers Association have started a full-scale study of the impact of medicine costs on the American public. This is part of a major public service program of the association, according to its president, Austin Smith, M.D.

Doctor Smith said the full resources of the association will be available for a broad study which will "bring together in one place information which has never been gathered in this country by any source, public or private."

Doctor Smith said the PMA will determine:

1. The extent of use of prescription drugs by the general population.
2. The segments of the population using drugs and under what circumstances.
3. The ways in which drugs are being provided in medical care programs.
4. Whether needed drugs are not available to patients.
5. Which elements, if any, of the population may be deprived of necessary drug therapy and the reasons for such deprivation if it exists.
6. The true relationship of prescription drugs to medical care needs and costs.

Helping to provide leadership for this study is the new association board chairman, Harry J. Loynd, president of Parke, Davis & Co. New chairman-elect of the group for 1961-62 is Eugene N. Beesley, president of Eli Lilly and Company, who spoke at the 1960 MCI in Detroit.



Report Half of Aged Have Health Insurance

The number of senior citizens covered by health insurance has increased from one out of four back in 1952 to a current one out of two.

This report, showing that 49 per cent of all Americans 65 and over had insurance at the beginning of 1960, is made by the Health Insurance Association of America.

Of the 15.7 million persons in this age group, an estimated 7.7 million had health insurance, the Association said in issuing the first analysis made on a nationwide basis since early 1958 of the extent of health insurance coverage among "senior citizens."

The report was based on coverage trends revealed in government and private surveys taken during the last decade and on developments in the health insurance business.

Because of accelerated activity by insuring organizations in this area, the growth of health insurance protection among persons sixty-five and older during the past eight years has been at a more rapid pace than for the population as a whole, said the Association, which is composed of 270 insurance companies.

In addition to the 49 per cent of the sixty-five-and-over who now have health insurance, the Association said, another 15 per cent, or 2.4 million persons, are officially classified as indigent, and provision is

made for their medical needs through Old Age Assistance, supported by Federal State matching fund programs. Such persons also receive money for food, housing, clothing and other needs.

Since 1952, the growth in coverage for the total population was from nearly six out of every ten persons to a little more than seven out of ten.

Indiana Study Shows Most Hospital Cases for Surgery

"A study of Indiana hospital records gives little support to the criticism that great numbers of patients are unnecessarily admitted to general hospitals or could be treated less expensively elsewhere."

That statement is made by George Bugbee, president, Health Insurance Foundation, following a study of the 1956 records of the Blue Cross Hospital Service of Indiana.

Mr. Bugbee pointed out that almost two-thirds of the cost of hospital care in the study group went for surgery, including obstetrical care—services in which hospitaliation is clearly indicated.

The study also showed that hospital costs vary according to what ails the patient, and while the average cost per admission in one study was $166, the range was from a low of $54 for diseases of the upper respiratory system to $503 for digestive cancer.

Among the major findings of the study were these.

1. Diseases of the digestive system accounted for a larger share of total hospital days than any other category—145.2 per 1,000 insured individuals a year, or one-sixth of the total days for all admissions.

2. Of all the major diagnostic categories analyzed, cancer was responsible for the longest average hospital stay, 15.5 days. Cancer patients also averaged the highest bills per admission, $387.

3. One-fifth of all hospital admissions were for obstetrical care, with an average stay per case of 4.6 days and a total hospital bill per admission $119.

According to this Indiana study by the Health Insurance Foundation, there were 115.5 hospital admissions per 1,000 in the covered population for all causes, and the average length of stay per admission was 7.3 days. Total hospital use, the product of the two factors, amounted to 838.8 days per 1,000 persons annually.

Hospital bills submitted to Blue Cross averaged $22.91 a day for room rate and other charges, or $166 for each hospital stay. These bills, when spread over the entire insured population (whether or not they were hospitalized) came to $19.22 per person per year, which corresponds closely to the average annual expenditure on hospital services of $22 in 1957-58 as reported by H.I.F. in February of this year.

Although the study was limited to Indiana, Mr. Bugbee stated, it has nationwide implications, particularly since hospital costs in Indiana appear to be close to national averages.

Health Insurance Benefits In State Up in 1959

Health insurance benefit payments by insurance companies to the people of Michigan climbed to a new high during 1959. In the period from January 1 through December 31, 1959, an estimated $157 million was paid out to help cover the cost of doctor and hospital bills and to replace income lost through sickness or disability.

This represented a gain of 2.2 per cent over the 1958 figure of $153 million, and is based on reports from insurance companies doing business in the state.

The rise in benefit payments in Michigan was reflected in the figures for the nation as a whole, the national Health Insurance Institute points out. Persons with health insurance received a total of more than $2.9 billion in benefits from their insurance company policies in 1959, up 9.6 per cent over the previous year's high of more than $2.6 billion.

Explains Armed Forces Need for Physicians

The Armed Forces continue to require the services of most physicians liable for military service under the Universal Military Training and Service Act.

Lt. Gen. Lewis B. Hershey, Director of Selective Service, issued this reminder to physicians when it became apparent recently that the Armed Forces would not call to active duty a small number of physicians in a few specialties who had been deferred for residency training under the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program.

All reserve officers deferred for residency in most specialties will be called.

Shortages exist and will continue in certain specialties and in the group of officers who have not specialized.

The Selective Service Director urged physicians not

(Turn to Page 876)

Explains Armed Forces Need for Physicians

(Continued from Page 874)

to draw erroneous conclusions concerning the need of the Armed Forces for their services. If a substantial number of physicians, basing their decision on knowledge that a few reserve medical officers in a few specialties are not being called to active duty after residency, conclude they are not needed, existing shortages in the Armed Forces will be aggravated.

The Department of Defense has found it unnecessary to requisition physicians through the Selective Service System since early in 1957. This has been so only because sufficient numbers of physicians sought reserve commissions and thus made themselves available for call to active duty.

There is a continuing need for applications for the residency program, as well as for reserve commissions and active duty at the conclusion of internship, General Hershey stressed.

There are temporary surpluses in some specialties in the residency program. Estimates of needs must be made four or five years ahead. Other factors are revisions in Armed Forces strength, redistribution of troops, reorganization of the hospital system, specialists choosing a military career, and voluntary extension of duty tours by reserve officers.

New Connecticut Plan Popular with Aged

One phase of the problem of assuring medical attention for the aged—low-cost prepaid medical coverage—is being successfully attacked by Connecticut Medical Service, that state's Blue Shield Plan, in cooperation with the Connecticut State Medical Society.

It is a voluntary, prepaid medical policy, known as the Special Individual Contract, available regardless of age, occupation, or condition of health. Within three months after it was launched, on April 1, 1959, some 23,000 members were enrolled, 42.6 per cent of whom were 65 years of age or older, and hundreds of new applications poured in each week thereafter, according to the physicians.

The contract, which is continuously available, carries benefits identical to the C.M.S. Preferred Contract—for members not eligible on a group enrollment basis—except that maternity benefits are excluded.

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Hematuria—With Special Reference to Asymptomatic Microhematuria

Laurence F. Greene, M.D.
Rochester, Minnesota

"Always he kept asking
Where did that blood come from?"
—*Ossawatomie* . . . CARL SANDBURG.

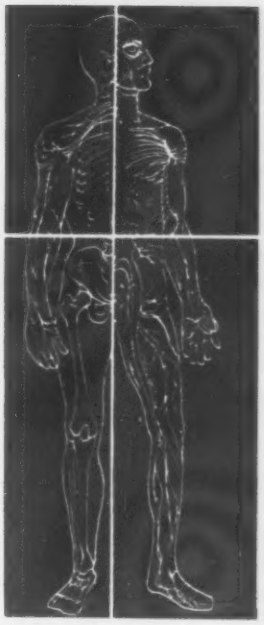
Gross Hematuria

HEMATURIA, although only a symptom, is indeed a significant symptom. There is an ancient Egyptian curse that says "May your blood turn to water." This imprecation would be equally effective if reversed.

A discussion of hematuria frequently begins with a scathing criticism of physicians who neglect to investigate every case of hematuria thoroughly. It is probable that the overwhelming majority of physicians are alert to this problem. Although patients who have extensive advanced lesions of the genito-urinary tract have been treated with drugs for months or years, too often it is the patient who refused the advice of his physicians and insisted that symptomatic treatment by given. Only an insignificant minority of physicians attempt to treat hematuria by medications. To this small minority of physicians, I earnestly suggest the reading of Carl Sandburg's somber poem "Ossawatomie," an excerpt from which heads this paper.

In the study of each patient with gross hematuria, a careful history is both desirable and necessary. However, it must be borne in mind that the history may be of little help, or even misleading, in regard to diagnosis. Only a few generalizations can be made in respect to the history. Thus a patient who complains of hematuria but no other urinary symptoms *probably* has a vesical neoplasm. Likewise, a patient who has noted moderate to severe flank pain and hematuria *probably* has a renal neoplasm. Finally, a patient who has scanty bleeding and severe colic is *probably* suffering from a stone. These probabilities require substantiation from urologic investigation. Furthermore, some physicians attempt to obtain diagnostic information from the fact that hematuria is initial, total or terminal in men. Here again, such observations represent probabilities. It is probable that if the bleeding is initial, which indicates that during the act of micturition the urine is first bloody but clears as micturition continues, the bleeding is prostatic in origin. However, it is possible for a vesical neoplasm to ooze blood which is washed out at the

Read at the meeting of the Wayne County Medical Society and the Detroit Urologic Society, Detroit, Michigan, April 13, 1959.
From the Mayo Clinic and Mayo Foundation, Rochester, Minnesota.



start of urination and thereby to cause initial hematuria. Similarly, one might expect that total hematuria, in which case the urine is bloody throughout micturition, represents a renal or vesical lesion. This

TABLE I. SOURCE AND CAUSE OF GROSS HEMATURIA IN 5965 CASES*

Source	Cases, Per Cent	Cause	Cases, Per Cent
Kidney	42.7	Inflammation	31.3
Bladder	29.6	Neoplasia	27.9
Prostate	14.1	Foreign body	20.0
Ureter	8.7	Tuberculosis	9.4
Urethra	4.6	Trauma	3.7
		Other	7.4

*After Doss.

is likely, but it may represent bleeding from the prostate with the blood passing back into the bladder and mixing with the urine. Finally, terminal hematuria, a condition in which blood appears only toward the end of urination, is usually due to an enlarged or inflamed prostate. On the other hand, it may result from pinching of a papilloma of the bladder when the bladder collapses.

Similarly, the physical examination, by virtue of absence of findings, may be misleading. Thus a diagnosis of renal neoplasm with probable metastasis can be made readily in the case of a cachectic patient who has renal pain, a hard mass, gross hematuria and an enlarged supraclavicular node. However, such gross findings will be encountered only rarely. Unless a neoplasm is of fair size, located in the lower pole and the patient thin, it is probable that it will not be detected by physical examination. A carcinoma of the renal pelvis may cause death and not be palpable. Furthermore, one cannot usually distinguish between a renal neoplasm, cyst, pyonephrosis and hydronephrosis by means of physical examination. The deficiencies of the history and physical examination, therefore, indicate the need for urologic investigation of all cases of gross hematuria. The form that such investigation will take will consist of, at a minimum, excretory urography and cystoscopy. More complicated cases may require other urologic diagnostic procedures.

Presentation of an imposing list of causes for gross hematuria is of doubtful value. It is sufficient to list the source and cause for gross hematuria in a large series of cases (Table I).

Extrarenal diseases may in some instances result in alteration in the appearance of the urine (Table II). The untrained eye of the patient may cause misinterpretation of the altered appearance and the false conclusion that hematuria is present. The absence of blood in the urinary sediment studied by microscopic means will distinguish these diseases from hematuria.

Emergency Management of Severe Hematuria.—What steps should be taken when one is confronted with a patient who is experiencing severe hematuria and frequency if urologic help is not available at the moment? Bleeding of such degree is usually caused by lesions in the bladder or prostate; renal lesions are less likely to produce such severe hematuria. First,

TABLE II. DISEASES IN WHICH APPEARANCE OF URINE MAY SUGGEST GROSS HEMATURIA

Disease	Responsible Substance
Porphyria	Uroporphyrin
Paroxysmal hemoglobinuria	Oxyhemoglobin, methemoglobin
Jaundice (obstructive or hepatocellular)	Bilirubin
Alkaptonuria	Homogentisic acid

it is necessary to reassure the patient that he will not bleed to death. Second, it is necessary to remove the blood clots from the bladder. This can usually be readily accomplished with a 20 or 22 F. catheter and an aseptic syringe. At times it is almost miraculous how the simple removal of clots will cause an immediate cessation of bleeding. It is wise to leave the catheter indwelling until urologic aid is available.

Asymptomatic Microhematuria

Urologists, in a consulting capacity, may be confronted with the problem of asymptomatic microhematuria several times daily. It is a simple matter to suggest urologic investigation, but such investigation, at a minimum, will include excretory urography, cystoscopy and possibly retrograde pyelography. The urologist has the clinical impression, however, on the basis of previous experience, that complete urologic investigation in the great majority of cases of this type fails to disclose the source or significance of the microhematuria.

It is equally simple, on the other hand, to advise that the microhematuria be disregarded. The urologist, however, will be disturbed by the recollection of a patient in whom urologic investigation, performed because of microhematuria, resulted in discovery of a neoplasm in the urinary tract.

A study was undertaken, therefore, to determine the incidence, nature and significance of urologic lesions associated with asymptomatic microhematuria. Also sought were criteria that would enable the urologist to decide whether or not urologic investigation is

necessary, and if so, the form such investigation should take.

The histories of 500 consecutive patients who had undergone urologic investigation because of asymptomatic microhematuria were reviewed. In each case urologic investigation consisted of excretory urography, cystoscopy and, when indicated, retrograde pyelography. In all patients microhematuria was the only abnormal finding on urinalysis; none of the patients had past or present urinary symptoms, and neither history nor physical examination indicated

TABLE III. INCIDENCE OF MICROHEMATURIA ACCORDING TO AGE AND SEX IN 500 PATIENTS

Age, Years	Total		Male		Female	
	No.	Per Cent	No.	Per Cent	No.	Per Cent
Less than 30	11	2.2	10	3.6	1	0.5
30-39	51	10.2	28	10.0	23	10.4
40-49	134	26.8	70	25.1	64	29.0
50-59	194	38.8	102	36.6	92	41.6
60-69	98	19.6	61	21.9	37	16.7
70 or more	12	2.4	8	2.8	4	1.8
Total	500	100.0	279	100.0	221	100.0
	Years					
Youngest	19		19		26	
Oldest	78		76		78	
Mean	52		52		52	

the necessity of urologic investigation. Such an investigation, in most instances, was undertaken only if microhematuria had been noted to persist in a second urinalysis. In men, voided specimens of urine were examined; in women, urine obtained by catheterization was employed for the second urinalysis.

At the Mayo Clinic microhematuria is classified in four grades. Microhematuria of grade 1 exists when one to eight erythrocytes are found per high-power microscopic field of a centrifuged specimen; grade 2, eight to thirty cells; grade 3, thirty cells to three fourths of the field; and grade 4, when the entire field is packed with erythrocytes.

Results

The 500 patients consisted of 279 men and 221 women. The incidence of microhematuria, according to decade of life, is shown in Table III. It will be noted that a greater number of older patients (fifty years or more) than of younger patients underwent urologic investigation because of microhematuria; this was due probably to the greater incidence of microhematuria among older patients and to selection of patients for study by the urologist.

Table IV, which shows the incidence of urologic lesions according to age and sex, indicates that increase of incidence is proportionate to increase in age; furthermore, lesions were found more commonly in men than in women.

In Table V the incidence of microhematuria accord-

TABLE IV. UROLOGIC LESIONS IN RELATION TO AGE AND SEX

Age (years) and Sex	Total Patients by Age	Urologic Lesions	
		No.	Per Cent
Less than 30	11	3	27.3
30-39	51	21	41.2
40-49	134	62	46.3
50-59	194	112	57.7
60-69	98	70	71.4
70 or more	12	10	83.3
Total	500	278	55.6
	By Sex		
Male	279	174	62.4
Female	221	104	47.1
Total	500	278	55.6

ing to grades is shown; in addition, the incidence of urologic lesions according to grade of microhematuria is noted. It may be observed that the incidence of urologic lesions is approximately the same in cases of microhematuria of grades 1, 2 and 3. The number of cases of microhematuria of grade 4 probably is too small to have statistical significance.

The nature and incidence of the urologic lesions are shown in Table VI; in addition, this table sets

TABLE V. INCIDENCE OF MICROHEMATURIA AND UROLOGIC LESIONS ACCORDING TO GRADE

Hematuria, Grade	Total Patients		Urologic Lesions	
	No.	Per Cent*	No.	Per Cent†
1	133	26.6	73	54.9
2	191	38.2	101	52.9
3	169	33.8	98	58.0
4	7	1.4	6	85.7
Total	500	100.0	278	55.6

*Based on 500 patients.
†Based on total cases in corresponding grade.

forth the incidence of the urologic lesions according to grade of microhematuria. The table shows that about 56 per cent of patients with asymptomatic microhematuria have urologic lesions.

Evaluation of Data

The observation that more than half of the patients had urologic lesions would appear to indicate that asymptomatic microhematuria is an omnious finding, and that urologic investigation of such patients is not only advisable but necessary. However, closer study of Table VI indicates that this simple answer may be misleading. This table indicates that there is a striking

difference in the significance of the lesions noted, ranging from renal neoplasm to verumontanitis. Certainly, urologic investigation, initiated because of microhematuria, which leads to detection of a renal neoplasm is highly desirable. It may be questioned, however, whether complete urologic investigation is indicated in order to inform a man sixty years old, who does not have urinary symptoms, that he has verumontanitis.

TABLE VI. NATURE AND INCIDENCE OF UROLOGIC LESIONS AND INCIDENCE ACCORDING TO GRADE OF MICROHEMATURIA

Urologic Lesion*	Patients		Microhematuria, Grade			
	No.	Per Cent†	1	2	3	4
	278	55.6	Patients			
Asymptomatic prostatic hyperplasia	118	23.6	22	51	43	2
Urethritis	106	21.2	35	32	38	1
Renal calculus	17	3.4	2	6	6	3
Cystitis	17	3.4	4	6	7	
Urethrotrigonitis	16	3.2	4	7	5	
Vesical neoplasm	9	1.8	1	2	6	
Prostatic calculi	9	1.8	1	3	5	
Renal cyst	6	1.2	4		2	
Urethral stricture	5	1.0	2	1	2	
Hydronephrosis	3	0.6		2	1	
Renal neoplasm	2	0.4	1	1		
Ureteral calculus	2	0.4	1	1		
Ureterocele	2	0.4	1	1		
Urethral polyps	2	0.4	1	1		
Occlusion of renal pedicle?	1	0.2			1	
Pyelonephritis	1	0.2		1		
Essential hematuria	1	0.2				1
Horseshoe kidney	1	0.2	1			
Renal agenesis	1	0.2		1		
Ureterectasis	1	0.2		1		
Pinpoint ureteral meatus	1	0.2		1		
Vesical diverticulum	1	0.2			1	
Verumontanitis	1	0.2			1	
Indeterminate	4	0.8		1	3	

*Since a patient may have more than one lesion, the total number of lesions will be greater than the total number of patients with lesions.
†Based on 500 cases.

It was thought that division of the lesions into categories based on their significance would help clarify this problem. The following three categories were selected: (1) significant lesions, (2) moderately significant lesions, and (3) insignificant lesions. A significant lesion was defined as one that is a clear, immediate threat to the patient's life or continued well-being or that requires major surgical procedures or that significantly alters the patient's way of life. A neoplasm, for example, clearly fits into this category. A moderately significant lesion was defined as one that causes slight, if any, alteration in the patient's way of life, requires minor or no treatment and appears to be a remote threat, if any, to the patient's continued well-being. A minute calculus located in a minor calyx of a kidney would be included in this category. An insignificant lesion was defined as one that does not require treatment, does not alter the patient's way of life and does not appear to be a threat to the patient's continued well-being. A mild degree of asymptomatic prostatic hyperplasia not associated with other evidence of a pathologic nature would be included in this last category.

TABLE VII. NATURE AND INCIDENCE OF SIGNIFICANT LESIONS AND INCIDENCE ACCORDING TO GRADE OF MICROHEMATURIA

Urologic Lesion	Patients		Hematuria, Grade			
	No.	Per Cent*	1	2	3	4
	24	4.8	Patients			
Vesical neoplasm	9	1.8	1	2	6	
Renal calculus	4	0.8		2	2	
Renal cyst	4	0.8	3		1	
Renal neoplasm	2	0.4	1	1		
Ureteral calculus	2	0.4	1	1		
Hydronephrosis	1	0.2		1		
Occlusion of renal pedicle?	1	0.2			1	
Urethral stricture	1	0.2		1		

*Based on 500 cases.

The lesions that were considered significant are shown in Table VII. It will be noted that a significant lesion was found in about 5 per cent of patients who had asymptomatic microhematuria. Neoplasms were discovered in about 2 per cent of the cases. The vesical neoplasms varied from small to extensive and, with a single exception, were papillary transitional-cell epitheliomas, grade 1 (Broders). An infiltrating transitional-cell epithelioma of grade 3 was observed in one instance. The renal neoplasms consisted of hypernephroma and a transitional-cell epithelioma of the renal pelvis. Every patient who had a significant lesion of the urinary tract was fifty years old or more; this observation will be referred to later.

A lesion of moderate significance was noted in about 5 per cent of patients (Table VIII), and an insignificant lesion was observed in about 45 per cent (Table IX). In the latter group, in particular, it was difficult to establish a relationship between the lesion and microhematuria. Thus, it could not be stated with certainty that mild prostatic hyperplasia, for example, was responsible for microhematuria. Finally, a lesion could not be found in about 44 per cent of patients with asymptomatic microhematuria (Table X).

TABLE VIII. NATURE AND INCIDENCE OF MODERATELY SIGNIFICANT LESIONS AND INCIDENCE ACCORDING TO GRADE OF MICROHEMATURIA

Urologic Lesion*	Patients		Hematuria, Grade			
	No.	Per Cent†	1	2	3	4
	23	4.6	Patients			
Renal calculus	13	2.6	2	4	4	3
Urethral stricture	3	0.6	1		2	
Renal cyst	2	0.4	1		1	
Hydronephrosis	2	0.4		1	1	
Pyelonephritis	1	0.2		1		
Essential hematuria	1	0.2				1
Horseshoe kidney	1	0.2	1			
Renal agenesis	1	0.2		1		
Ureterectasis	1	0.2		1		
Pinpoint ureteral meatus	1	0.2		1		
Vesical diverticulum	1	0.2			1	

*Since a patient may have more than one lesion, the total number of lesions will be greater than the total number of patients with lesions.
†Based on 500 cases.

An effort was made to determine whether the incidence of significant urologic lesions was greater in cases in which microhematuria was of higher grade, that is, grade 3 or 4, than in cases in which it was of grade 1 or 2. If this hypothesis could be established, it might indicate that urologic investigation could be confined to patients who have higher grades of microhematuria. This hypothesis could not be established. Study of Table V indicates that the incidence of lesions is essentially the same regardless of whether microhematuria is graded 1 or 2 or 3 (the number of patients who had hematuria of grade 4 probably is too small to have statistical significance). Of more importance is the fact that the incidence of significant lesions was not greater when hematuria was of higher grade than when it was of lower grade.

TABLE IX. NATURE AND INCIDENCE OF INSIGNIFICANT LESIONS AND INCIDENCE ACCORDING TO GRADE OF MICROHEMATURIA

Urologic Lesions*	Patients		Hematuria, Grade			
	No.	Per Cent†	1	2	3	4
	227	45.4	Patients			
Asymptomatic prostatic hyperplasia	118	23.6	22	51	43	2
Urethritis	106	21.2	35	32	38	1
Cystitis	17	3.4	4	6	7	
Urethrotrigonitis	16	3.2	4	7	5	
Prostatic calculi	9	1.8	1	3	5	
Ureterocele	2	0.4	1	1		
Urethral polyps	2	0.4	1	1		
Urethral stricture	1	0.2	1			
Verumontanitis	1	0.2			1	

*Since a patient may have more than one lesion, the total number of lesions will be greater than the total number of patients with lesions.
†Based on 500 cases.

Comment

Urologic investigation of 500 patients with asymptomatic microhematuria disclosed a significant or moderately significant lesion in about 10 per cent of patients; the lesion was neoplastic in about 2 per cent of patients. The remaining 90 per cent of patients fell into approximately equal groups, in which either the lesion noted was insignificant or a lesion could not be detected.

TABLE X. OCCURRENCE OF MICROHEMATURIA IN PATIENTS WITHOUT UROLOGIC LESIONS ACCORDING TO GRADE OF MICROHEMATURIA

Microhematuria, Grade	Patients
1	60
2	90
3	71
4	1
Total	222*

*44.4 per cent of 500 patients.

The study failed to disclose any factors that will permit the urologist to distinguish microhematuria of significant origin from that of insignificant origin; this can be accomplished by urologic investigation only. The grade of microhematuria is not decisive. Microhematuria of grade 1 or 2 was noted slightly more frequently than was microhematuria of grade 3 or 4 among patients with significant lesions. The most malignant lesion in the entire series, an extensive hypernephroma, was found in a patient who had microhematuria of grade 1.

My colleagues and I believe that complete urologic investigation should be performed in all cases of asymptomatic microhematuria. This conclusion is based largely on the fact that a lesion of varying significance will be discovered in about 10 per cent of cases. Furthermore, such investigation will permit the physician to reassure the remaining 90 per cent of patients that the cause of the microhematuria either is not significant or cannot be detected. It is not difficult to recall numerous other diagnostic procedures that yield a smaller percentage of positive results.

If the urologist desires to carry out urologic investigation in selected cases, there appears to be an alternate, although less acceptable, plan for the study of patients with asymptomatic microhematuria. It was noted in this study that each patient who had a significant urologic lesion was fifty years old or more. Urologic investigation, according to this alternate plan, would consist of excretory urography and cystoscopy if the patient is fifty years of age or older, and a plain roentgenogram of the urinary tract, plus cystoscopy, if the patient is younger than fifty years. The alternate plan would, according to analysis of the statistics given in this paper, permit the detection of all significant urologic lesions, more than three fourths of the lesions considered to be moderately significant, and all lesions that are considered insignificant.

Persistence of microhematuria sometimes is employed as a basis for determination of the necessity of urologic investigation. When this method is used the patient submits specimens of urine for analysis weekly or biweekly for four to six weeks. If microhematuria is noted in a majority of specimens, urologic investigation is instituted. This plan of action is based on the supposition that microhematuria is more likely to be persistent when the lesion is significant than when the lesion is of lesser significance, or when a lesion cannot be detected. This supposition appears logical, but has not been established as fact.

Several possible causes for microhematuria were noted in about 41 per cent of patients in the present study in whom urologic investigation yielded normal findings: (1) normal urine may contain erythrocytes; (2) it is probable that in some instances erythrocyturia results from trauma incidental to physical examination; and (3) erythrocyturia may result from subclinical urologic or other disease of the kidneys.

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New Film Available to Professional Audiences

"The Cancer Detection Examination," a black-and-white 16 mm. film, produced by Eli Lilly and Company, is now available for showing by professional groups. The film, which is forty-six minutes in length, demonstrates the presymptomatic detection of cancer. Using procedures developed by the Strang Cancer Detection Clinic, New York, Emerson Day, M.D., demonstrates and narrates an examination useful in the office of the private physician. An illustrated booklet covering the same material is available for distribution at time of showing.

For booking, write to Eli Lilly and Company, Indianapolis, Indiana, requesting the film thirty days before desired showing date.

Acute Pelvic Abscess in Duplication of the Sigmoid and Uterus

C. C. Eades, M.D., and
E. O. Jodar, M.D.

Grosse Pointe Woods, Michigan

THE CLINICAL features and management of the case to be presented, seem worthy of comment because of a rare combination of congenital anomalies as a cause of pelvic abscess.

Duplications of the alimentary tract may occur at any point between the tongue and anus.[1-3] However, sigmoid colon duplications appear in the larger series reported, with marked infrequency. Sigmoid duplication in conjunction with double uterus is exceedingly rare.[1-3]

That these duplicative anomalies appear to be more frequently recognized and properly managed by the surgeon without specific pediatric surgical training is evident; ascribable, no doubt, to the teaching influence of the surgical department of Childrens Hospital of Boston, Massachusetts.[2-4]

In 1934, Ladd and Gross[3] reviewed 121,515 pediatric hospital admissions in which 162 instances of imperforate anus and associated anomalies were encountered. Listed among the associated anomalies, duplication of the uterus was noted in a single instance. In 1941, these authors[3] restudied the material listing a series of eighteen cases up to 1940 and reporting a single case of duplication of the sigmoid. Since 1940, R. E. Gross[4] and associates have studied an additional forty-nine cases treated at the Children's Hospital. A single case, of duplicated sigmoid not previously reported, was added.

The earliest reference to duplication of the hind[3] gut appears to have been made in the eighteenth century publication *Ephermides* of the Leopoldine Academy, published in Frankfurt, Germany, in 1712. Present-day reference lists starting at the turn of the century all include mention of the case reported by Lockwood[5] in 1882. At autopsy a condition, which is of historical interest, was found represented by Lockwood's original sketch here reproduced (Fig. 1).

A. W. Gray[6] (1940) reported the autopsy findings of an eleven-month-old girl who had been admitted for vomiting, fever, abdominal distention and pyuria. The baby expired in a pattern of intestinal obstruction. Examination revealed triplication of the colon and numerous associated anomalies. These were: Exstrophy of the bladder; non-fusion of the pubic rami; absence of the vagina and external genitals; perineal fecal sinus; imperforate anus. He continues:

"Displaced laterally by the distended blind colons were rudimentary internal genital organs. On the left, the tube and ovary were compressed against the pelvic wall and were connected with a narrow fibrous cord, which represented the Müllerian duct. On the right, the same condition existed except that the ovary and most of the tube had herniated into the canal of Nuck. There was no fusion between the Müllerian ducts to form a uterus. There was slight bilateral hydronephrosis."

The case history we present is notably similar to one reported in 1914 by Roux de Brignoles[7] who discovered duplication of the colon at operation for acute appendicitis.

On the scale of anomalies, the case here reviewed, seems to be about in the middle zone of the extremes pointed out by Gray's report and that reported in 1947 by Ladd and Chrisholm.[8] In the latter instance, the authors describe the management of a girl, twelve years and five months old, covering several hospital admissions, two laparotomies, and two perineal procedures before the real nature of the anomalies was unraveled and definitive surgery was successful. These anomalies were reported to have been duplication of the uterus, vagina, and rectum. It will be noted that the sigmoid colon was not involved, and therefore we feel that the case report which follows is unique.

THE AUTHORS

C. C. Eades *(left)*

E. O. Jodar *(right)*

Case Report

D. K., girl, aged eight years, was admitted ambulatory September 3, 1958, and discharged September 6, 1958.

The following history was obtained: This well developed and well nourished child developed lower abdominal pain

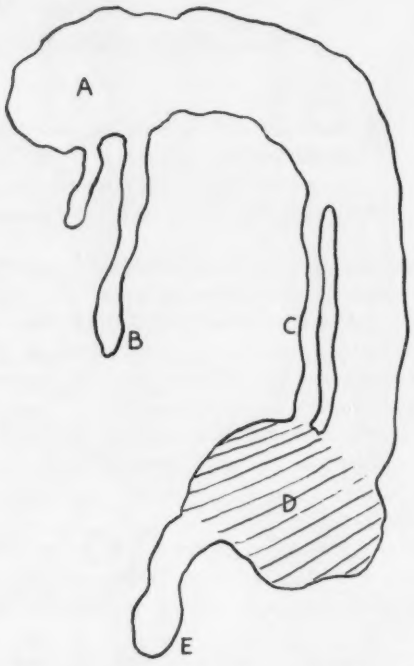

Fig. 1. A traced reproduction of Lockwood's illustration of 1882: (A) caecum and appendix, (B) terminal ileum, (C) diverticulum, (D) malignant disease mass, (E) rectum.

three days prior to admission. She vomited several times during the next twenty-four hours and complained of urinary frequency. The bowel movements were stated to have been normal in character and frequency, but of a dark color.

The house doctor on admission found a scaphoid abdomen with no rigidity but with tenderness in the right lower quadrant. There were normal bowel sounds and no palpable masses.

Laparotomy was performed for acute appendicitis by others than the authors. The operator's dictated report indicated that "the appendix was moderately edematous but without exudate. The mesenteric glands were enlarged. There was no Meckel's diverticulum. The intra-peritoneal fluid was increased and escaped as a clear serous fluid without odor."

The postoperative course up to the day of discharge on the second postoperative day was not remarkable except for patient-management problems which the surgeon felt could be better resolved in the home environment.

The pathologist's report was as follows: "The gross surgical specimen is an appendix 10 x 0.8 cm. The serosal surface is markedly congested and covered with a thin fibrinous exudate. The muscle wall is edematous and the lumen is segmented and packed with fecal material."

Microscopic diagnosis: obstructive appendicitis.

The interval history between September 6, 1958, and the readmission date of September 27, 1958, is obscured by emotional fog generated by the parents, neighbors, and relatives. However, a few salient points broke through. The child continued a down-hill course marked by weight loss of approximately six pounds, dyspepsia, diarrhea, anorexia, fever, abdominal pain, rectal tenesmus and the passage of "golden-frothy stool" which later became very dark. There was increasing lower abdominal distress, obstipation, vomiting, fever and "passage of urine every few minutes."

On the day following admission, September 28, 1958, one of us wrote the following progress note: "abdominal mass, about grapefruit size mostly on the left but across the midline. Rectal examination shows mass, not too low down but firm. *Diagnosis:* (1) Ovarian cyst. (2) Post-appendicitis abscess."

On this re-admission, the hospital laboratory reported: WBC 15,600; segmented neutrophiles 80 per cent; micro hematocrit 26 vol. per cent; Hb. 8.5 gm.; RBC 3,000,000; Color index .99; urine: color, yellow, slightly cloudy. Reaction pH 5, alb.; trace; sugar 0; acetone 4, diacetic 0, bile 0. WBC 5-7, RBC 3-5, epth. cells rare; rare granular cast.

Radiologist Report, September 28, 1958:

1. *Acute Abdomen Series.*—Survey films of the abdomen show the presence of a large rounded tumor which gives the impression of arising from the pelvic cavity and extending upward to the lower border of the fourth lumbar vertebra. The nature of the mass cannot be determined radiographically. There are no calcifications or gas shadows within the mass. There is no dilatation of the small or large bowel.

2. *Barium Enema.*—A barium enema was performed under fluoroscopic observation which showed considerable pressure upon the sigmoid colon by the soft tissue mass. The sigmoid is displaced upward and somewhat to the right by the mass. The mass also produced pressure upon the caecum which was also found to be displaced upward.

Conclusions.—Rather large soft tissue mass which appears to arise from the pelvis, producing pressure and displacement of the colon. The caecum is not deformed. I rather doubt that the mass originates from the appendix. It may well represent a pelvic neoplasm.

Consultant Surgeon's Note.—Eight-year-old female who appears chronically ill and anemic with marked evidence of recent loss of weight. The temperature curve during the past thirty-six hours is of the "spiking" type. The child has a "pinched" facial expression and is extremely apprehensive. Dehydration is evident. The lower abdomen is rounded out by a firm fixed smooth mass rising to the level of the umbilicus; more evident to the left. The bladder cannot be made out by percussion. Bowel sounds are about normal throughout the remainder of the abdomen. Abdomino-rectal bimanual palpation indicated the same findings. The rectum

was empty of feces. What appeared to be a thinned out patulous cervix could be felt through the anterior rectal wall.

Impression in Decreasing Probability.—

1. Adnexal tumor (infarcted dermoid).
2. Uterus didelphys with hemato-pyometra and peritonitis.
3. Meckel's diverticulum abscess.
4. Tubo-ovarian abscess.
5. Post appendiceal pelvic abscess.

(b) Duplication and abscess of the sigmoid and recto-sigmoid colon.

(3) Cloacal vestiges.

Operation.—(Fig. 2) The lower abdomen of this eight-year-old girl was opened to the left of the midline between the umbilicus and the symphysis. Sero-sanguinous exudate escaped in large quantities on opening the peritoneum; colon

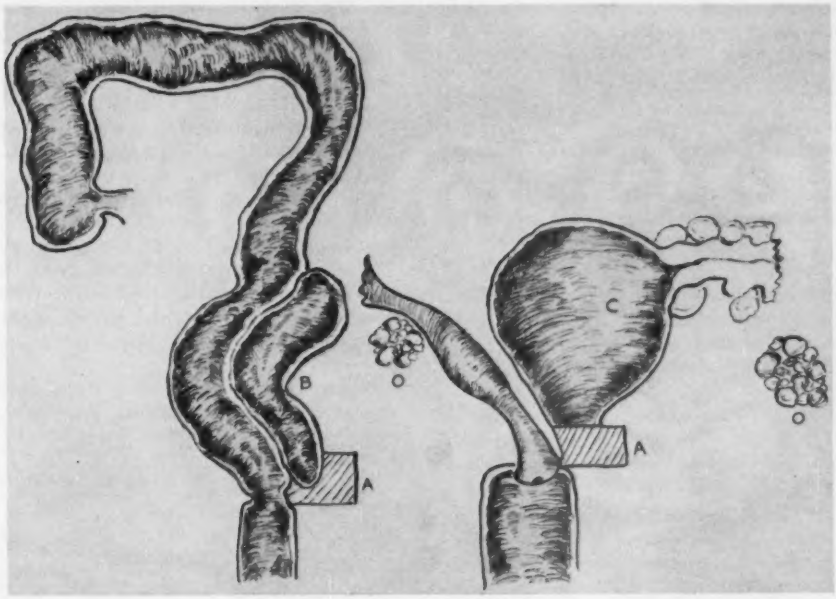

Fig. 2. Exploded diagrammatic representation of the superimposed genital and colonic structures observed at operation. (A) site of abscess and communication of the two systems, (B) duplication of sigmoid colon, (C) uterus didelphys, left element, with fallopian tube, (D) ovaries.

Approximately 48 hours after admission and 24 days since the laparotomy for appendicitis by another surgeon, the patient was re-explored.

Preoperative Diagnosis, September 29, 1958:

1. Post appendectomy pelvic mass, pelvic peritonitis, toxic anemia, pyrexia.

2. Probability of anticipated pathology:
   (a) Solid ovarian tumor (infarcted dermoid).
   (b) Uterine didelphys with pyometra and localized peritonitis.
   (c) Acute salpingitis.
   (d) Post-appendicitis abscess.
   (e) Meckel's diverticulum abscess.

Postoperative Diagnosis.—

1. Phlegmonous pelvic tumors consisting of multiple congenital anomalies involving the sigmoid colon and internal genitals: as

   (a) Uterus didelphys with pyometra and pyosalpinx.

bacillus odor was detected. The pelvic cavities were completely filled to the level of the umbilicus by two firm reddish-gray necrotic masses covered with sero-fibrinous exudate. These masses consisted of two distinct elements each containing a pinkish thick exudate of about 250 cc. After evacuation of these necrotizing cysts, the smaller of the two, proved to be a duplication of the sigmoid colon to the level of pelvic floor (Fig. 2A). Here the lower end of the sigmoid duplication joined the larger thicker walled inflammatory cyst. The latter proved to be the left element of a uterine didelphys which had received a perforation from the duplicated colon at (A) (Fig. 2). The left tube was surrounded by multiple thin-walled cystic inclusions. The left ovary appeared to be buried in the infundibulo-pelvic ligament.

The bladder and right uterine horn were flattened against the right pelvic wall and the conformation of the bladder suggested a duplication of this organ. However, a left sided accessory bladder and ureter could not be made out in this necrotic and hemorrhagic field.

The left didelphys and tube were removed down to a cuff in the pelvic floor representing a possible duplicated cervix.

The edge of this cuff was over-sewed for hemostasis and subsequent marsupialized drainage.

Both barrels of the duplicated sigmoid colon were resected and primary anastomosis between the low rectal segment and the mobilized descending colon was carried out in two layers. A decompressing caecostomy was made through a right flank incision using a No. 30 Foley catheter. Multiple Penrose drains were placed deep in the pelvis to the left lower uterine remnant. The abdomen was closed in anatomical layers after placing within the peritoneal cavity a solution containing two grams streptomycin and 1,000,000 units of penicillin. The patient required 700 cc. of electrolite fluids and 600 cc. of whole blood during this long procedure. She was sent to the recovery room in good condition.

Gross Pathological Diagnosis.—

1. Inflammatory phlegmonous polycystic and infarcted pelvic mass.
2. Segment of infarcted large bowel.
3. Inflammatory smooth muscle tissue.

Microscopic Diagnosis.—

1. Diffuse purulent phlegmonous inflammation of large bowel with abscess formation.
2. Phlegmonous inflammation of uterine tissue.
3. Large pelvic organized abscess.

Pathologist's Remarks.—The sections of the bowel represent congenital duplication of the upper rectum and sigmoid colon. The portions of the uterus represent a didelphys uteri.

Postoperative Course.—The child made a satisfactory recovery room response and was returned to her room with: (a) naso-gastric tube, (b) caecostomy tube, (c) indwelling catheter in urinary bladder.

Sero-sanguinous wound discharge was abundant but bowel sounds appeared within the first twenty-four hours after surgery. The naso-gastric tube was removed in forty-eight hours and oral fluids retained. The alimentation progressed to normal within the next seventy-two hours. Electrolytes and blood were administered in quantities indicated by the blood chemistry status. Caecostomy drainage was very slight during the first seventy-two hours and consisted of gas and liquid ileal contents.

The patient began to pass gas per anum on the third postoperative day and liquid stool per anum on the fifth postoperative day.

The stools were soon semi-formed and contained no mucus, blood or pus. There was no discharge from the vagina. The urine remained clear. The spiking temperature decreased by lysis and the caecostomy and pelvic drains were removed on the ninth postoperative day. Fecal or urinary fistulae did not develop and there was no enzymatic digestion of the wound edges.

The child was afebrile on the fifteenth postoperative day. Stools, appetite and morale were normal. The caecostomy wound had closed and the midline drainage site was near closure by secondary intention. The child was discharged improved.

Follow-up.—D. K., aged eight, was readmitted to the pediatric service of St. John Hospital on December 28, 1958, three months after resection of double sigmoid and left uterus didelphys. The mother's statement to the pediatrician indicated constipation and the passage of blood "with every stool" during the past week. The child had gained nine pounds since last operation. As in the past, the exact nature of the child's complaints were difficult to evaluate from the mother's statement.

On admission, the urine was clear, Sp. Gr. 100.7; pH acid; albumin 0; sugar 0; acetone 0; micro occ. squamous epithelial; hemoglobin 12.3 gms; micro-hematocrit 37 (control 40); WBC 6,950; neutrophiles 52 per cent; lymphocytes 48.

Intravenous Pyelogram, December 29, 1958.—K U B discloses the liver, spleen and kidneys to be normal in size and configuration. The psoas shadows are sharply outlined on each side. The bone structures are not remarkable.

There is no evidence of abnormal calcific density in the renal areas or along the course of the ureters.

After intravenous injection of dye, films were taken at five, fifteen, and twenty minutes. There is excellent concentration of the dye on each side indicative of good function. The pelves are of average intrarenal type and infundibuli and calices are normal bilaterally. The ureters are well demonstrated and there is no evidence of duplication or other anomaly. The ureters have a normal appearance on each side.

At the end of the study, there is a good cystogram which shows no evidence of abnormality. The upright study shows normal downward excursion of the kidneys in the upright position.

After evacuation, there is almost complete emptying of the urinary bladder.

Conclusions

The intravenous pyelogram on each side is well within normal limits. The ureters are normal in caliber and course. The urinary bladder is within average limits. There is no evidence of anomaly of the genito-urinary system. We do incidentally see considerable constipation within the rectum and recto-sigmoid region of the colon.

Procto Sigmoidoscopy and Vaginal Endoscopy Under Anesthesia

Vaginal Endoscopy.—An infant's procto-sigmoidoscope was used for vaginal endoscopy under anesthesia. A single normal cervix uteri was visualized. The vaginal fornices were carefully ironed out under good illumination. Anomalous vaginal openings were not seen.

Sigmoidoscopy.—The colo rectum was well prepared and empty. The standard procto-sigmoidoscope was passed under direct vision to and beyond the colo-rectal anastomosis which was found to be unconstricted and with an intact mucosa. No bleeding points, ulcers, or evidence of inflammation were seen.

Summary.—Normal colo-rectal tube with recent anastomosis without visible disease. Normal external, vaginal and cervical findings. The child was discharged with a final diagnosis of relieved fecal impaction and melena incident thereto.

Comment

The points of clinical interest detailed in this case report, having a bearing on the diagnostic problems, met in surgery of the young are:

1. The pattern of intestinal obstruction,[9] complete or partial, is in evidence in all reviewed cases of a similar nature. Urinary tract disorder is frequently part of the clinical picture.

2. The experience obtained from this case emphasizes the need for careful pre-operative examination and study.[7]

3. Duplicative anomalies of the sigmoid colon demand resection of both barrels because of the common blood supply of both elements of the duplication.

4. The female infant or child should be suspect, in the acute abdomen-syndrome, when an indefinite clinical history is obtained, and when the objective abdominal findings are grossly atypical of acute appendicitis, and are suggestive of space-filling pelvic masses.

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Ask Reports on Drugs

A program for the reporting of unusual or adverse reactions to drugs has been developed by the Food and Drug Administration. It will be conducted initially with a limited number of hospitals selected to represent a cross section of medical specialties. Where necessary, contracts may be negotiated with the hospitals (or individual physicians designated by them) providing for reimbursement.

As the program develops, it is planned that additional hospitals will be included with the aim of establishing nationwide reporting. The project is an outgrowth of a voluntary pilot study carried out during the past four years in cooperation with the American Association of Medical Record Librarians, the American Society of Hospital Pharmacists, the American Medical Association, and the American Hospital Association.

The program is designed to develop information promptly on the untoward effects of drugs, especially the newer drugs. The information will be utilized by FDA in the resolution of medical and administrative problems under the Federal Food, Drug, and Cosmetic Act.

Pectus Excavatum

A Critical Evaluation of Treatment

Giovanni Chiappe, M.D.
J. H. Hertzler, M.D., F.A.C.S.
Detroit, Michigan

EXPERIENCE with medical and surgical treatment of pectus excavatum in patients of the pediatric age group has often left much to be desired. Since World War II, when the importance of the secondary complications of pectus excavatum were again pointed out, many different techniques have been devised for treatment. There are now a great variety of individual variations in technique which further indicate that no one procedure has proven entirely satisfactory. The stimulus for surgical repair of pectus excavatum arose from the unusually high incidence of cardiopulmonary changes demonstrated in young adults of the draft age. Our experience has been limited exclusively to treatment of pectus excavactum in individuals of the pediatric age group. It is this group which appears to be the age at which repair should be undertaken if future myocardial and respiratory damage is not to result.

Etiology

Maldevelopment of the anterior musculature of the diaphragm with a shortening of the central tendon has been described by Brown[1] and many other authors.[2-4] Nevertheless, in this series early exploration of the chest of infants and children with pectus excavatum because of other prior existing pathology has failed to disclose any central tendon or abnormal diaphragmatic attachment which could be demonstrated as an etiological factor in pectus excavatum.

The senior author has explored the thorax and mediastinum of children ranging in age from the newborn to twelve years of age with pectus excavatum defects hoping to find a central tendon which could be incised, without success. The newborn infant (not included in this series) had esophageal atresia with tracheal fistula. One child explored at thirteen months of age had eventration of the left diaphragm. Another child's thorax was explored at eleven years of age for the removal of a segment of homologous rib strut in a repair of pectus excavatum. Further evidence to indicate that the central tendon fixation of the sternum is not a reasonable explanation, is the fact that often the point of greatest angulation of the sternum can be demonstrated as well above the diaphragmatic fixation. The insertion of the central tendon on the posterior border of the xipho-gladioliar junction may be as much as four to five centimeters below the point of greatest depression of the sternum.

The authors favor the etiological explanation of an acquired defect due to fetal position. It is theorized that if arms and legs are appropriately pressed into the thorax during fetal life, the defect is created early in the formative stages of the skeletal system. Brown, in his original article, mentioned this as a probable factor.[1] Without the opposing forces of longitudinal bone growth, the ribs and costocartilages are allowed to increase in length to an abnormal degree, thus increasing and perpetuating the acquired funnel chest deformity. The negative pressure in the chest probably assists in perpetuating this development. The typical round shouldered slumping habitus of children with a mild pectus deformity can further increase the severity of the skeletal defect.

Lesions similar to funnel chest have been described in children and young adults who are apprentice shoemakers. The pressure of instruments on the center of the chest, day after day, produces a depression at the distal one third of the sternum and xiphoid

CO-AUTHOR
J. H. Hertzler

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From the Department of Surgery, Children's Hospital of Michigan and Harper Hospital, Detroit, Michigan.

process. This acquired deformity can displace the heart to the left and produce symptoms. Since this may occur in a growing child, extremities firmly applied on the sternum and the flexed fetal position may easily produce an intrauterine pectus excavatum.[1]

chosen, are specifically symptomatic, and are of the appropriate age and stage of development.

As mentioned by many others,[5-7] the optimal age of correction is between two and one-half to four years, but at the same time, there is considerable

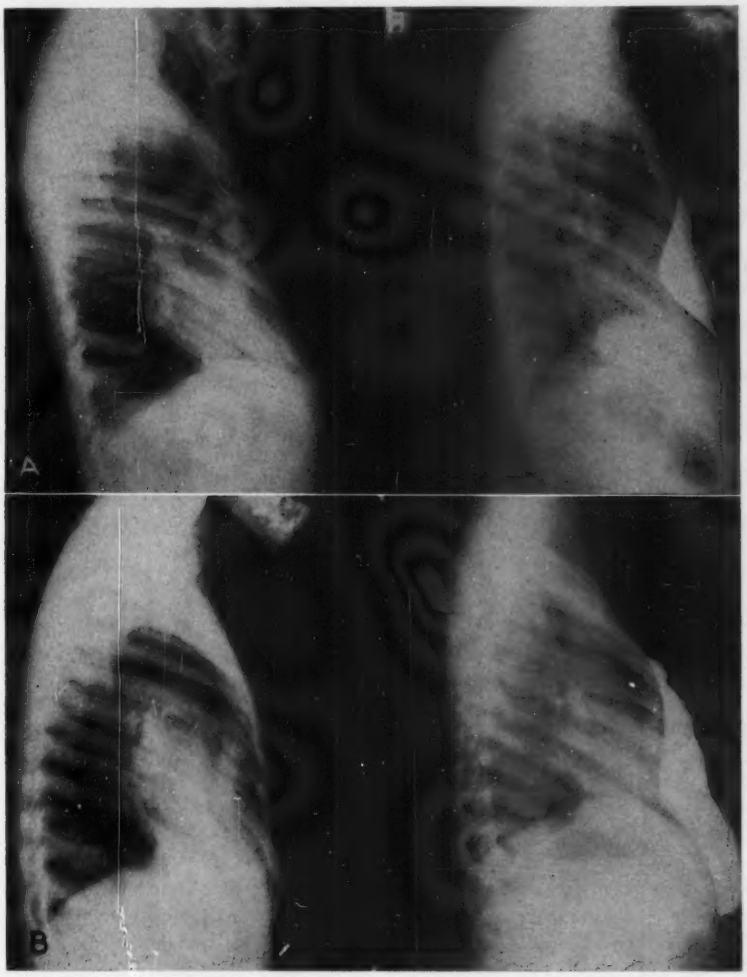

Fig. 1. (A) The lateral roentgenogram of the chest on the left is that of a four-year-old boy. The roentgenogram on the right is of a two and one-half-year-old girl. Both demonstrate the greatest posterior displacement of the sternum to be several centimeters above the diaphragmatic attachment. (B) Both lateral roentgenograms are of the same six-year-old white girl. The left is exposed during inspiration the right during expiration. The inspiratory roentgenogram shows the greatest depression of the sternum well above the diaphragmatic attachment.

Indications for Treatment

Because the cosmetic and functional results from repair of pectus excavatum are not always entirely satisfactory regardless of the method employed, it is important that the patients to be treated are carefully

variation in development and fixation of the thorax in the individual child. Some four-year-old children may still have a relatively unstable anterior chest wall which has considerable paradoxical activity. If such a child's symptomatology is not sufficiently acute to

warrant immediate surgery, he would be benefited by medical management and supportive treatment until the thorax is more developed and mature. On the other hand, some children have been seen at two years

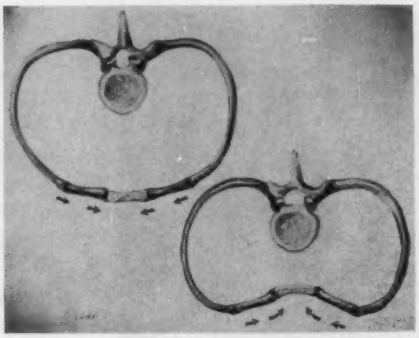

Fig. 2. This diagram shows the normal directly opposing forces of longitudinal bone growth in the normal thorax. As demonstrated in the presence of a pectus excavatum deformity, these forces do not oppose and therefore permit over growth of the ribs with increase in the pectus excavatum deformity.

of age who already had a relatively fixed anterior chest wall with very little paradoxical activity. Such a chest could not be expected to improve under any form of medical regimen and therefore surgical intervention, if necessary, could and should be undertaken at this age.

Reviewing the literature, it is common to find three reasons to undertake the surgical repair of pectus excavatum. They are[4,7-10] physiological, psychological and cosmetic indications. We find it difficult to justify a pectus excavatum repair for purely cosmetic purposes. There are several reasons for this feeling. First and foremost, the cosmetic results regardless of technique are not sufficiently reliable to make a guarantee of a cosmetically perfect chest. Secondly, much can be gained in efficiency and effectiveness as well as improvement of the cosmetic appearance of the chest through a purely medical exercise regimen. Third, the presence of a large scar across the most prominent portion of the anterior chest wall may well be more obvious and a source of more psychologic trauma than the pectus excavatum itself. Therefore, only strictly physiologic and symptomatic indications are justified for the repair of pectus excavatum.

Severe cardiac embarrassment is rare, nevertheless a variety of symptoms can be found due to the displacement of the heart to the left. The continuous pressure of the pectus on the heart can produce areas of ischemia in the myocardium and other electrocardiographic patterns such as partial heart block and arrythmias.

Less serious, but more frequent among patients of the pediatric age group, is the increased susceptibility to respiratory infections, as well as the increased difficulty when a respiratory infection is contracted. These children characteristically have a moderately severe pectus excavatum with considerable paradoxical activity of the anterior chest wall which results in an inefficient respiratory system. Under such circumstances the child's tussive activity is greatly decreased. Such a child is obviously prone to tracheal bronchitis and pneumonitis and is poorly equipped to combat these infections once they develop.

A third group of symptoms are those related to poor general development and unusual ease of fatigue. This may or may not be associated with symptoms of cardiac or pulmonary nature. It is not unusual, however, to see a child who appears malnourished, weak, and chronically exhausted with a moderately severe pectus excavatum. It is therefore our feeling that the presence of any one of the three or a combination thereof is indication for surgical repair. We do not feel that purely cosmetic reasons are justifiable at this time.

Material

Our impressions are the result of twenty-two operations on twenty patients with pectus excavatum treated during a period of seven years (1952 through 1958) at Children's Hospital of Michigan. The total number of patients with pectus excavatum treated surgically represent approximately 50 per cent of patients with this anomaly under observation and treatment. Fourteen were boys and six girls. The youngest patient was one year old and the oldest thirteen years old. There was only one colored patient in this series, a girl. Familial tendencies were present in three cases: two had grandfathers with the same defect and the remaining case had a twin brother with a "pigeon breast" deformity.

There were no cases of acute respiratory distress at birth as a cause of the pectus excavatum, but bronchial asthma was present in two of our cases, in one of these since two weeks of age.

All the patients fell into one of three indications for surgery listed elsewhere. Mild anorexia, ease of fatigueability, weight loss, pallor, shortness of breath, palpitations and even cyanosis (one patient) were recorded symptoms. A history of frequent colds were

present in almost all patients. Other anomalies were present in three patients: one had a diaphragmatic eventration, which was repaired prior to the pectus excavatum; another was a Mongol and a third had

age for repair. We were gratified to note that patients who had borderline defects were often sufficiently improved after a six month or more period of conscientious exercise that they were definitely removed from

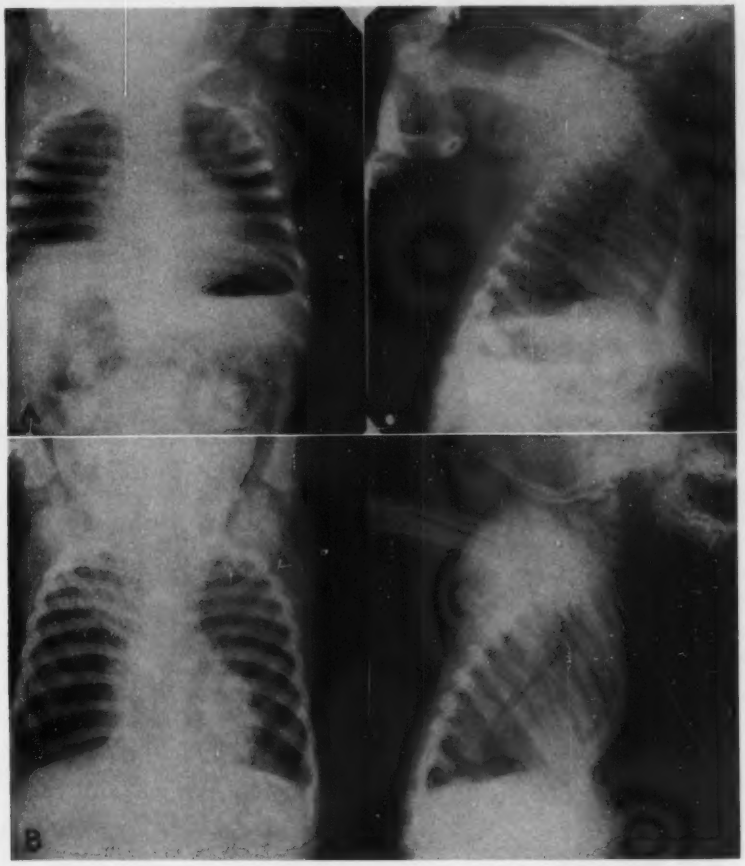

Fig. 3. (A) Roentgenograms show a mild pectus excavatum deformity in an eleven-month-old girl. (B) The same child a year later at twenty-three months of age shows marked increase in severity of the pectus excavatum as well as bilateral upper lobe pneumonic infiltrations.

cerebral palsy. Each of these had repeated severe respiratory infections. The deformities were all from moderate to severe. The heart was deviated to the left or in the center in all except one patient where it was located in the right chest.

Medical Treatment of Pectus Excavatum

A program of conservative therapy in the management of pectus excavatum was devised to supply the parents of children with this anomaly some form of treatment for their child while awaiting the optimal

the class where surgical intervention was considered. As a result of this experience, there seems to be a specific indication for a program of medical management of pectus excavatum. The patients who are subjected to this form of therapy fall into three categories.

1. Those patients in the so called borderline group whose cardiopulmonary and developmental findings are not sufficiently remarkable to warrant immediate surgical intervention. 2. Those children who are too young or whose chest wall has still not sufficiently matured for an optimal repair. 3. Young adults who

have passed the more vigorous physically active phase of life and now consider the repair of the pectus excavatum defect for purely cosmetic or psychogenic reasons.

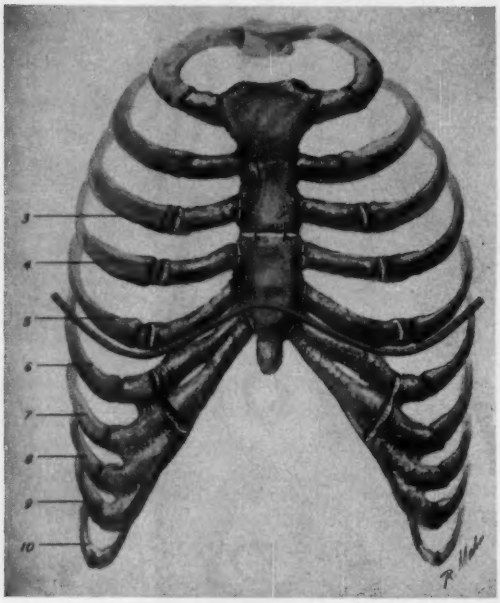

Fig. 4. The diagram of the thorax demonstrates the essential steps of the surgical correction of pectus excavatum as described in the text.

The medical regimen consists of efforts to improve the efficiency of the cardiorespiratory system. The first step in the medical program is:

1. The removal of all obstructing tissues in the airway. In the pediatric age group this means hypertrophied adenoids and/or tonsils which partially or intermittently obstruct the airway, thus exaggerating the existent funnel chest deformity and paradoxical motion of the anterior chest wall.

2. In the armamentarium of medical treatment is postural exercises. Characteristically, these children sit in a slumped, round shouldered position which exaggerates the protuberant abdomen and the sunken distal sternum. When the child's shoulders are retracted and he is forced to sit or lie in a flat position the defect is often minimized. Orthopedic braces and other mechanical devices to maintain good posture have proved to be quite unsatisfactory so far as the patient, parents and doctor are concerned. We have therefore encouraged the mothers to make a "bolero type" jacket for these children. The jacket must be cut narrow in the shoulders and have a relatively narrow strip over the anterior shoulders. This vest-like jacket will "cut" the child in the shoulders anteriorly whenever he slouches into the typical habitus. Careful attention to posture alone has been quite gratifying in many instances.

3. The muscular exercises prescribed in the medical management of pectus excavatum are designed to strengthen and develop the accessory respiratory muscles. In particular the pectoralis major and minor, the trapezius and supra-scapularus are of particular importance in this phase of the treatment. The development of these muscle groups affects three desirable results: (a) A generally improved cosmetic appearance of the chest because of the filling out of the upper anterior chest wall by the increased bulk of the pectoralis major muscle; (b) posture will improve with the development of the trapezius and supra-scapularus muscles by their increased tone and mass; (c) as accessory respiratory muscles, the pectoralis groups have a superior and anterior lifting force on the rib structures and may therefore contribute somewhat to correction of the angulation of the ribs of the anterior chest. The exercise program prescribed consists of pushups, chinning, rowing and activities which are designed to develop the muscles of the shoulder girdle. In children the velocipede type of tricycle which is pumped by pushing and pulling a handle bar has proven to be a satisfactory toy to aid in this phase of the treatment.

4. Breathing exercises are as important as any of the above in the completion of the medical therapy program. Such exercises take the form of breath holding, balloon blowing, musical instrument blowing, blow bottles, *et cetera*. These activities teach the child to more effectively and efficiently use what pulmonary reserve he has and by exercise and education to actually increase the effectiveness of his respiratory efforts. The program outlined for the medical management of pectus excavatum has done much to convince the parents and doctor that the particular patient, under consideration, should or should not be subjected to surgical operation.

Surgical Treatment

The dissatisfaction with several of the accepted surgical techniques for repair of pectus excavatum is

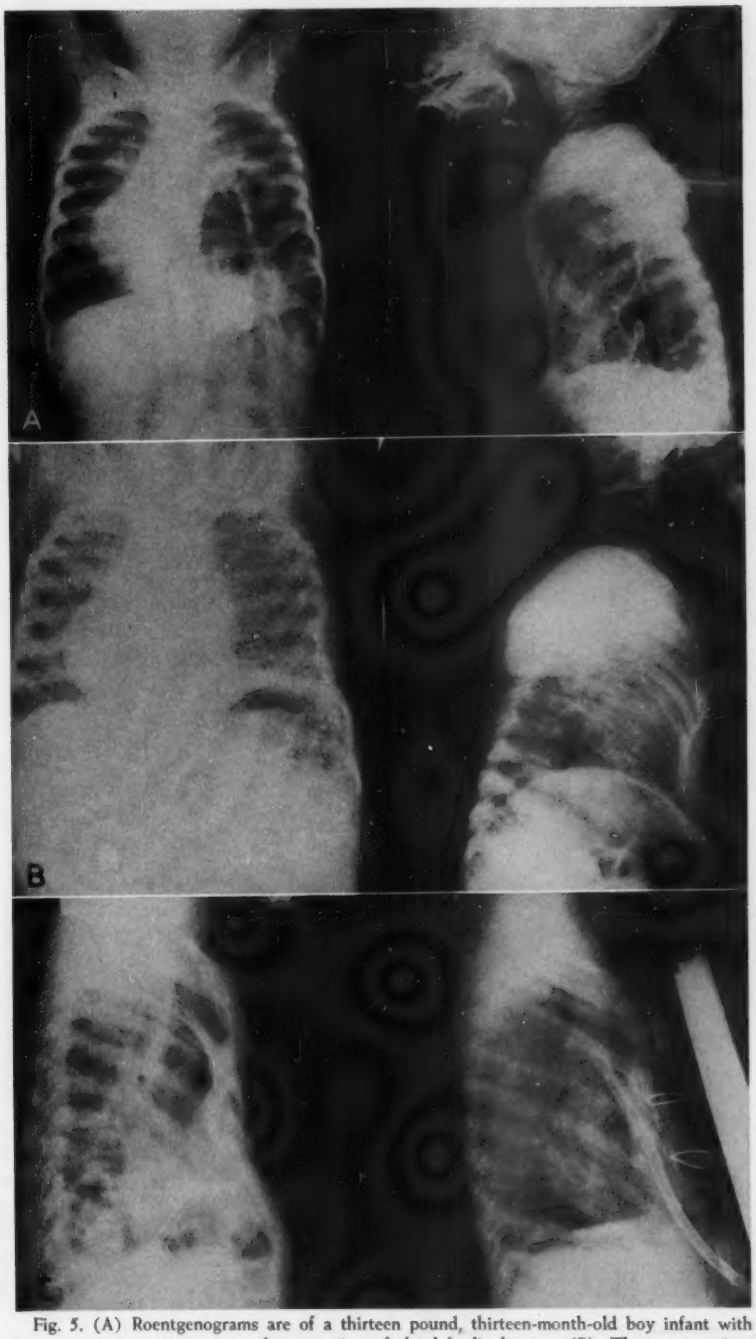

Fig. 5. (A) Roentgenograms are of a thirteen pound, thirteen-month-old boy infant with a severe pectus excavatum and eventration of the left diaphragm. (B) The same patient seven months later after repair of the left diaphragmatic eventration followed in two months by an autogenous rib strut repair of the pectus excavatum. (C) The left lateral roentgenogram of the same patient eighteen months after the rib strut pectus repair shows a large osteofibrotic mass on the posterior surface of the sternum which markedly shortens the anteroposterior diameter of the chest. The lateral roentgenogram on the right shows the external traction apparatus atfer resection of the rib strut with marked increase in anteroposterior diameter of the patient's chest.

the result of a long term evaluation of the ultimate results achieved by these various techniques. The immediate complications have actually been few in number and minimal in significance. If the patients are carefully chosen for surgical intervention on the basis of clinical symptoms, they are generally improved following surgical repair and have a minimal immediate morbidity. It has been the late complications arising six months or more following surgery that have prompted the dissatisfaction and modification of various surgical techniques. At the present time the author believes that the minimal amount of dissection necessary to correct the pectus deformity and adequately stabilize the anterior chest is attained by resuturing the costocartilages to the sternum.

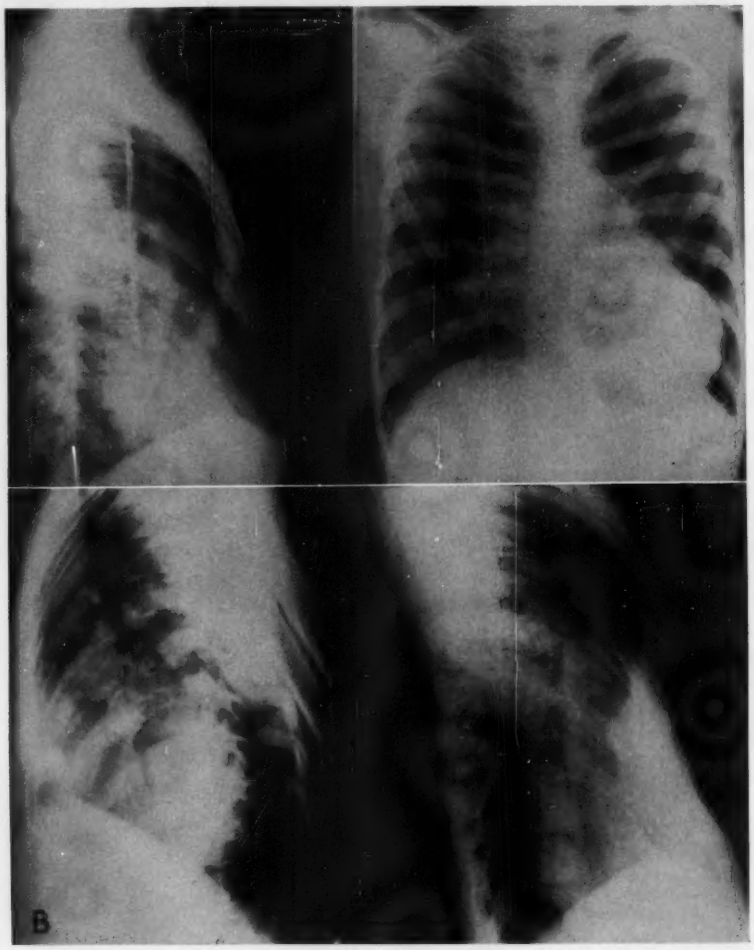

Fig. 6. (A) Preoperative roentgenograms on an eleven-year-old boy reveal marked shortening of anteroposterior diameter and displacement of the heart to the left. Note also the marked cephalo-caudal tilt of the ribs as the result of the abnormal length. (B) The left roentgenogram shows the autogenous rib strut in place one month after surgical repair. The lateral roentgenogram on the right demonstrates the large fibrotic mass on the posterior border of the sternum, which again severely shortens the anteroposterior diameter.

Routine steps in this type of operation are the following:

General anesthesia with indotracheal intubation is utilized in all cases. A transverse incision in the infra-mammary fold from nipple line to nipple line has been proved adequate. The superior and inferior

flaps are developed and the pectoralis major and rectus muscles exposed. The third, fourth, fifth, and sixth ribs and costal arch are exposed bilaterally at the junction with the sternum by stripping the muscle from its insertion. The xiphosternal junction is next divided and by blunt dissection the posterior surface of the sternum and the pleural reflections are freed of the mediastinal structures. The costo-sternal junctions of the exposed ribs are divided. The sternum lays free and a transverse osteotomy is done at the level of greatest angulation. The osteotomy is on the anterior surface of the sternum. The sternum is then angulated at the desired level and kept in this position by suturing the periosteum with 00 silk sutures. Similar osteotomies are done at the level of major angulation in each rib and excess costal cartilages removed. The costal cartilages are reapproximated to the sternum using 00 silk mattress sutures. A number 30 stainless steel wire is passed under the sternum and brought through the skin in the midline to be attached to an external traction apparatus. The anterior mediastinum is always drained and chest tubes are inserted if the pleura has been opened. The pectoralis fascia is approximated in the midline in the closure.

Complications

It is unfortunate that the medical literature is so plentifully supplied with articles describing various surgical techniques and the good immediate results achieved with the technique in a limited number of patients over a relatively short period of observation. At the outset of our experience in repair of pectus excavatum, we used the technique of partial resection of the costocartilages, sub-perichondrially, a transverse sternal osteotomy and external traction fixation. This technique, although relatively simple and easily carried out, often resulted in parasternal retraction of the rib ends so that the ultimate deformity following pectus excavatum repair was very similar to that of a pigeon breast. The next surgical procedure employed was the use of the homologous and autogenous rib struts as a means of fixation, thus replacing the external fixation. This technique, although reasonably satisfactory at the outset, resulted in months to come, in the development of a large fibro-osteotic mass on the posterior border of the sternum and anterior chest wall. In several instances this mass was more successful in shortening the AP diameter of the chest than the original pectus deformity.

It therefore became necessary to resect the rib strut and resort to external fixation. In any of the instances in which rib struts were employed, no evidence of wound infection which might have caused an increase in the amount of reaction appeared. Gradually, after these various experiences, the technique described above was developed. The results achieved by this method are uniformly good functional results and generally give satisfactory cosmetic results.

Results of Treatment

Sixteen of the twenty patients reported were operated at least two years prior to this study. The two patients re-operated have been followed for periods of four and five years since the second operation. The functional results in the sixteen patients have been uniformly good. In several specific instances, the children were under additional careful observation because of cerebral palsy, Mongolism, and speech defects. These trained observers noticed remarkable increase in stamina with a more progressive development following surgical repair. It was generally noticed that children in the lower twenty-five percentile of the weight and height scales, have gradually moved into the middle percentile groups. Those children in whom severe recurrent respiratory infections were the indications for surgery have shown a definite decrease in the incidence and severity of the infections. Many other examples of less obvious evidence of improved function and reserve have been recorded in the observations of satisfied parents.

The above-described operation does not assure a perfect cosmetic touch; asymmetry and slight over-correction adjacent to areas of slight under-correction have resulted in chests the appearance of which is not entirely satisfactory. The result of experience with several other procedures leads us to believe that asymmetry and variations in degree of correction are less with this operative technique than with those in which more extensive resections are carried out. There has been no instance in which the cosmetic result, or failure to achieve a satisfactory functional result, necessitated consideration of re-operation.

Summary

1. The authors believe that fetal position and resulting forces of bone growth play the primary role in the development and perpetuation of pectus excavatum deformity.

2. The indications for surgical treatment for pectus excavatum should be those based on physiologic signs and symptoms. The author does not feel that the

cosmetic results, regardless of operative technique, justify repair of pectus excavatum for purely cosmetic reasons.

3. The advantages and disadvantages of various surgical techniques have been discussed briefly and the authors modified technique presented.

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Discusses Concern of Women

"The concern women of all ages, particularly teen-agers, have over the dimensions of their bosoms can have a pronounced effect on the individual's social and emotional behavior—an effect that can lead to illness," said Dr. Edward R. Pinckney, an internal medicine specialist of Beverly Hills, California.

In an editorial in the May *New Physician*, official journal of the Student American Medical Association, Dr. Pinckney said, "As a sign of our times, the dimensions of women are recorded on almost every page of our newspapers and magazines, given prominence in the movies and on television, and have even become a popular topic for conversation.

"The young girl between nine and nineteen is a competitive individual," Dr. Pinckney continued, "and her greatest concern is with her appearance and the need to be 'average.' Therefore, in our day and age, it is a healthy sign when such a girl, or her parents, consults a physician regarding small breasts." The woman who has had many children may experience the same social difficulties as the teen-ager, but here the treatment is quite different.

"If no congenital, hormonal or nutritional cause is found, and if the psychic factor seems within reason, after the matter has been discussed with the patient and parents, the acceptance of a soft molded rubber pad is the simplest solution, according to specialists in the field of endocrinology and gynecology."

the blue shield record

News in the field of prepaid health care for the doctors of Michigan

The *Journal's* special Blue Shield issue, published each June, is a valuable communications opportunity. It gives Michigan Medical Service a much appreciated occasion to report its activities to the members of the Michigan State Medical Society and to all members of Michigan's medical community.

The House of Delegates recognized the need for more frequent Blue Shield reports when, last September, it adopted a resolution calling for improved communications between Michigan Medical Service and Michigan physicians.

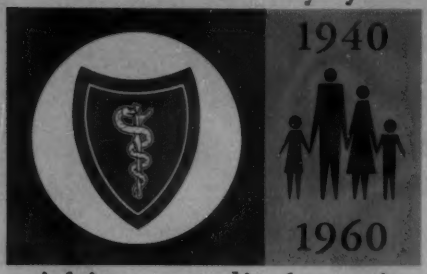
A Professional Relations Committee of the Michigan Medical Service Board of Directors is already hard at work toward this goal. In addition, professional relations liaison committees of hospital staffs and component medical societies are now being formed to provide effective communications on a two-way basis.

The relatively new *Blue Shield Record*, written to convey news of Blue Shield and prepayment to physicians, will be Michigan Medical Service's prime bearer of general information to Michigan's doctors. Hence, the use of the *Blue Shield Record* logo to introduce this annual Blue Shield issue of the *Journal*.

G. Thomas McKean, M.D.

G. Thomas McKean, M.D.

20th anniversary year



michigan medical service

contents

A MATTER OF FINANCES

An editorial

BY A.C. FURSTENBERG, M.D.

READING TIME: 1 MINUTE

Financing medical care is no longer a purely personal matter in this country. It has become a resounding social and political issue.

Congress is interested in health care finances, as are the Presidential candidates. The newspapers abound in announcements of hearings, studies, plans, proposals and counter-proposals. Needless to say, the man in the street is interested, too.

We have been warned repeatedly in recent years that the country is gravitating toward a sort of national health service. As a matter of fact, the warnings have been so frequent and so uniformly strident that the ear is in danger of becoming immune, just as it becomes inurred to familiar noises.

I don't wish to add to the din. I wish simply to say that I believe Americans in general would be eager to avoid a government-medicine program if they could feel they have an acceptable alternative.

I believe that a most acceptable alternative is Blue Shield, for Blue Shield has almost always been sensitive and alert to the needs and the desires of doctors and the public and, therefore, has come closer than any other mechanism to providing the kind of health care financing that is generally desired and needed.

I believe that if Blue Shield continues to display this kind of sensitivity and flexibility, the medical profession, through Michigan Blue Shield, will provide the kind of program that will render government medicine not only unnecessary but unwanted.

However, passing resolutions won't do it. Anti-government-medicine press kits won't do it. Talking at each other won't do it.

Providing the best voluntary prepayment program ourselves *can* do it.

M-75— MISSION ACCOMPLISHED

READING TIME: 2 MINUTES, 15 SECONDS

Early this year, Michigan Blue Shield accomplished an 18-month job that proved to be as paradoxical as it was difficult. The problem: Meet a public demand for a higher level of medical-surgical benefits (at a necessarily higher cost); then attempt to sell this higher cost program at the peak of a serious economic recession.

The new, better and more expensive benefit level was M-75, and had its beginning with the Michigan State Medical Society's 1957 survey to determine what the public and the doctors of Michigan wanted in the way of prepaid medical-surgical care.

The results of that study led to the principles which were adopted by the MSMS House of Delegates in 1957 (reconfirmed by the House in 1958) and given expression in the resultant M-75 contract.

The M-75 program was put on the market during the last half of 1958. However, with recession-inspired caution, many individuals and organizations took a hard second look at the higher cost of the broader M-75 benefits and the accompanying Blue Cross rate increase, many of them deciding to stay with the less effective, but less costly, $2,500-$5,000 Blue Shield contracts.

M-75 rates represented benefits in uncharted areas of prepaid care for which relatively little reliable experience data were available. Furthermore, M-75 rates were established at a self-supporting level, and they were not intended to subsidize the older Blue Shield contracts. But this, in fact, is what happened. The delay in conversion of groups from $2,500-$5,000 to M-75 contracts caused the lower-rated, older contracts to drain about $1 million of income from M-75 and it became imperative to accelerate the lagging conversion. So Blue Shield, with MSMS approval, sought acceptable expedients that would tend to reduce buyer resistance.

First, it introduced a deductible contract that would sell at a lower rate and meet with less resistance on the part of the

buyer. Second, it offered Income-Not-Certified contracts to groups which normally would buy certified contracts, thus enabling the buyer to select lower income ceilings at lower rates, albeit at a slight reduction in benefit level. (Nevertheless, individuals within the group still retained the option of choosing the appropriate income ceiling for service benefits.)

During that year, Michigan Blue Shield and its companion plan, Michigan Blue Cross, lost a number of groups to commercial insurance companies which, through their flexibility of programming, were able to capitalize on the recession by offering a lower degree of benefit at lower rates.

To what degree the medical profession's controversy over M-75 affected the rate of conversion is impossible to determine, but it seems reasonable to assume that it produced a degree of doubt and confusion about Blue Shield in the minds of members and the public.

The controversy had centered mainly around the method of paying non-participating doctors; around income ceilings based on subscriber income rather than family income; and around the level of the new $7,500 income ceiling. These problems were treated by the House of Delegates in September, 1959 in these ways: 1) The House reaffirmed the then existent policy that non-participating doctors be paid directly by Blue Shield only if the patient provided an assignment which was to be incorporated in the Doctor's Service Deport; 2) the House resolved that income be based on family income, rather than subscriber income; 3) the House called for implementation of a maximum family income ceiling of $6,500 as soon as feasible.

The House also asked that Michigan Medical Service continue, in the meantime, to sell M-75 contracts.

Today, the conversion job is virtually an accomplished fact.

According to schedule, 96 per cent of Blue Shield contracts on May 1 represented M-75 coverage.

MICHIGAN BLUE SHIELD ENROLLMENT

M-75 GROUP	CONTRACTS	MEMBERS
M-75 Group		
Plan A	99,309	200,460
Plan B	286,139	753,750
Plan C	404,035	1,296,083
Plan D	112,295	389,239
Sub-total	901,778	2,639,532
M-75 Group Deductible		
Plan A	137	196
Plan B	548	1,481
Plan C	373	1,261
Plan D	188	623
Sub-total	1,246	3,561
Pending	1,888	5,233
Sponsor Dependent Rider		3,107
Family Continuation Rider		1,622
Total M-75 Group	904,912	2,653,055

M-75 GROUP CONVERSION		
M-75 Group Conversion		
Plan A	64,150	98,479
Plan B	31,188	75,086
Plan C	9,704	29,084
Plan D	3,326	9,964
Sub-total	108,368	212,613
M-75 Deductible Group Conversion		
Plan A	1,807	3,244
Plan B	1,581	4,401
Plan C	674	2,177
Plan D	326	1,022
	4,388	10,844
Total M-75 Group Conversion	112,756	223,457

M-75 NON-GROUP		
M-75 (Under Age 65)		
Plan A	41,333	72,193
Plan B	17,275	41,249
Plan C	5,386	16,458
Plan D	3,520	10,001
Sub-total	67,514	139,901
M-75 (Senior)		
Plan A only	4,726	4,726
Total M-75 Non-Group	72,240	144,627
TOTAL M-75:	1,089,908	3,021,139

$2,500 GROUP	CONTRACTS	MEMBERS
Surgical	11,769	26,783
Medical-Surgical	69,032	173,621
Sub-total	80,801	200,404
$5,000 GROUP		
Surgical	6,629	21,666
Medical-Surgical	49,145	137,816
Sub-total	55,774	159,482
Total $2,500-$5,000 Group	136,575	359,886
Pending	2,362	5,848
$2,500 GROUP CONVERSION		
Surgical	5,047	9,661
Medical-Surgical	14,166	26,216
Sub-total	19,213	35,877
$5,000 GROUP CONVERSION		
Surgical	1,145	2,301
Medical-Surgical	7,419	16,302
Sub-total	8,564	18,603
Total $2,500-$5,000 Group Conversion	27,777	54,480
$2,500 NON-GROUP		
Surgical	21,286	45,277
TOTAL $2,500-$5,000	188,000	465,491

TOTAL MICHIGAN BLUE SHIELD CONTRACTS	1,277,908	**TOTAL MICHIGAN BLUE SHIELD MEMBERS**	3,486,630

"PAYCHECK" FOR THE BLUE SHIELD BOARD OF DIRECTORS

READING TIME: 1 MINUTE, 15 SECONDS

"Section 9. No compensation shall be paid to any Director for services as a Director, but reimbursement for actual and reasonable expenses may be authorized by the Board."

Thus, the by-laws of Michigan Medical Service make clear that any compensation for the time, effort and interest expended by members of the Blue Shield Board of Directors must take the form of the personal satisfaction that derives from doing good work for the public and the medical profession.

How hard do Blue Shield Directors work for this non-monetary reward?

Well, in 1959, the Board put in almost 700 man-hours during *regular sessions* of the Board of Directors.

They put in more that 380 man-hours at *special meetings.*

They put in 670 man-hours as members of various *committees of the Board.*

Total time at the meeting table: *about 1,750 man-hours.*

That's an average of about *52 man-hours per member* per year.

Those figures represent officially-recorded meetings. They do not include the hours of hard work put in by a Director at his desk at home or on the telephone. They do not include the time he spends traveling on Blue Shield business — in all kinds of weather.

But no man-hour total can ever measure the wear and tear on the nervous system of an already overworked man who, somehow, always manages to find a little more time, a little more energy to devote to a job that he knows needs doing and that somebody has to do.

An old saw says that when you want a job done, you call on a busy man to do it. Blue Shield is fortunate in having so many busy men on its board.

BLUE SHIELD TESTIMONY ON THE AGED

READING TIME: 3 MINUTES, 30 SECONDS

On the afternoon of December 11, 1959, G. Thomas McKean, M.D., President of Michigan Medical Service, appeared at the Detroit hearings of the U.S. Senate Subcommittee on Problems of the Aged and Aging to relate the ways in which Michigan Blue Shield has, and is, providing medical-surgical protection for persons 65 years of age or more.

In a statement filed on behalf of Blue Shield, Dr. McKean told the subcommittee that Blue Shield, in September of 1959, had introduced a contract for persons who are 65 years of age or older and that the contract had been developed in response to resolutions adopted by the American Medical Association and the Michigan State Medical Society in December 1958.

Of Michigan's 650,000 senior citizens, Dr. McKean said, approximately one-half are believed to have some sort of health care protection. About 175,000 senior citizens are in the State's working force, he said, and are assumed to have some sort of group medical-surgical coverage, either through Michigan Blue Shield or through commercial insurance companies. More than 9,000 have the new Blue Shield Senior contract, he said, and another 150,000 are covered by Blue Shield under formal retirement programs, through Non-Group contracts or through Group Conversion contracts.

In relating the origin of the new Senior contract, Dr. McKean described the relationship between Blue Shield M-75 scheduled fees to average fees charged by Michigan's physicians. Surgical fees payable by Blue Shield for subscribers earning in excess of $5,000 per year were 107 per cent of the average Michigan charge, while M-75 scheduled surgical fees acceptable to Blue Shield participating doctors for subscribers with incomes less than $2,500 a year were 71 per cent of the average Michigan charges.

"Thus, in the existing $2,500 income limit plan under M-75, Blue Shield had, in fact, the basis for a medical-surgical contract

for senior citizens," Dr. McKean told the subcommittee.

He pointed to two basic and traditional Blue Shield characteristics that were retained in the Senior contracts: 1) The service principle, which protects the oldsters from unpredictable out-of-pocket expenses, and 2) The community-rating principle, under which Blue Shield provides this coverage for all aged persons at the same rate, $3.24 per month.

He pointed out that Senior citizen contract holders pay their own way as a group because "it is not the prerogative of Michigan Blue Shield to burden other Blue Shield contract holders with a portion of the cost of medical care for the aged . . ." However, he said that a degree of subsidization takes place in the Blue Shield actively-employed groups and in groups with formal retirement programs in which the ages of members vary widely from young to old, although the rates are the same for all subscribers holding the same type of contract.

Dr. McKean told the subcommittee that the introduction of the Blue Shield senior contract filled "the last void in prepaid medical-surgical coverage for the aged—the void that represented those persons who did not obtain coverage from Blue Shield or commercial sources before attaining age 65, and those whose commercial coverage had no conversion privileges upon retirement."

Said Dr. McKean: "Blue Shield has, since its inception, maintained a policy of not cancelling coverage except for failure to pay subscription fees or for fraud. As a result, many of the aged population in Michigan have long been protected and continue to be protected by other forms of Blue Shield contracts."

He listed five other methods by which persons 65 years of age or more now have Blue Shield coverage:

1. Group enrollment (active employment).
2. Formal retiree groups (group benefits at group rates for retirees where the subscriber's employer has a formal pension or retirement program and where the payroll deduction mechanism is made available to the retired persons for purposes of making possible group remittance to Blue Shield).

3. Group Conversion contracts (available to any person who leaves an enrolled Group).

4. Non-Group contracts for persons enrolling before reaching age 65 (available since 1951 and non-cancellable, regardless of age).

5. Sponsored Dependent Rider (which enables a group subscriber to provide an aging dependent with Group Conversion coverage at Group Conversion rates).

Dr. McKean concluded: "In summary, Mr. Chairman, I would like to point out that, in establishing the Blue Shield prepayment corporation, the Michigan State Medical Society has attempted to meet the public's need and demand for this type of medical expense budgeting system. The success of this effort, I believe, is attested by the public's receptiveness to it. It has proved to be not only a large organization, but a dynamic one, which is clearly demonstrated by the fact that it now makes available to every citizen in the State of Michigan the opportunity to obtain Blue Shield coverage. And it is the assumption of the medical profession of Michigan and Michigan Medical Service that future growth in this area of protection is imminent. It is further agreed among those of us in the field of health care that within 8 or 10 years, when these various programs have had opportunity to mature, most of our senior citizens will be provided for through voluntary agencies and that legislation by the Congress to install a government system to supplant this voluntary method will be unnecessary."

THE COMMERCIALS— HOW THEY COMPETE

READING TIME: 2 MINUTES

Comprehensive major medical health insurance is one of the hottest items on the prepaid health care market today. Its broad scope of coverage appeals to the individual consumer. Its competitive rate appeals to the sophisticated group purchaser who buys fringe benefit programs with a sharp eye on costs.

Major medical has gaps and weaknesses, some of which will be pointed out herein, but the fact remains that it is a highly salable short-range expedient for holding down the costs of the employer.

The most common characteristics of major medical care are:

1) The deductible, requiring a certain expenditure by the patient before all or most of the benefits begin. The deductible ranges from $25 to $500, but usually is $100.

2) The co-insurance feature which requires the patient to pay a part of the bill, with the carrier assuming the balance. The patient's portion usually ranges from 20 to 25 per cent.

3) The ceiling feature which places a dollar limit on the carrier's liability. Ceilings range from $2,500 to $20,000, centering around $5,000 for a single illness and $10,000 for two or more, renewable upon proof of recovery of the patient.

Sometimes major medical is written atop a primary coverage such as Blue Cross-Blue Shield. Or it may be written atop a straight $500 allowance for service while in the hospital, followed by the co-insured benefits after deductible, or without any primary coverage, in which case the deductible and co-insurance become effective immediately. The use of such deductibles and co-insurance enables the carrier to reduce its liability, and to set rates at a level competitive with, or below, service plans.

Two other areas in which major medical underwriters pare costs are maternity care and in-hospital medical care.

Maternity coverage — a high incidence item — usually is treated as a separate area of benefits. About half the commercials cover maternity care with a flat maximum benefit — generally about $250 for both hospital and professional services. Many

control the tension—treat the trauma

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greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.) widely accepted tranquilizer and...

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.
PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.
PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.
Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

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Each gram contains:
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Zinc Bacitracin ..... 400 Units
in a special petrolatum base.

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Zinc Bacitracin ..... 500 Units
in a special petrolatum base.

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simply exclude "routine" pregnancy entirely. Abnormal maternity cases frequently are treated on a straight co-insurance basis, with a deductible thrown in. Sometimes, maternity care does not cover the newborn until the baby is two weeks old or is readmitted to the hospital. Some carriers simply exclude routine nursery care. The savings to the carrier are considerable since maternity admissions represent a high percentage of the total (about 20 per cent for Blue Cross).

Medical cases also represent a large percentage of total admissions (about 42 per cent for Blue Cross). Seldom does major medical have a primary or first-dollar benefit unless it is written over a primary. Sometimes the plans with the $500 in-hospital allowance will pay medical benefits out of that $500. But when the hospital charges also must be taken from the same amount, the $500 obviously does not go far. In most instances the bulk of the medical benefit is subject to the deductible and the co-insurance.

The $500 allowance before deductible and co-insurance, as well as most major medical benefits, relates to periods of illness, and renew on proof of complete recovery. The effect is to reduce liability on the chronic cases for which the catastrophic costs are most likely to accrue.

Commercial major medical contracts also usually include at least several benefits outside the basic benefit area; e.g., ambulance service, blood, private nursing, prosthetic appliances and take-home drugs, almost always with a deductible.

These coverages have weaknesses, but when cost is a prime factor, major medical often wins consideration.

The cost factor is one of major medical's strongest promoters today. Most health coverage is purchased through a group employer, frequently by a sophisticated management man who must think as much about price as about quality. Prepaid health care has become a direct cost of being in business and the margin of profit in modern business frequently is slim, so overhead costs are closely watched and regulated lest they offset the narrow cushion of profit. The business executive, therefore, attempts to fix or stabilize as many costs as possible. Major medical, with its non-service-benefit structure, lends itself to this expediency.

In recognition of the market's receptiveness to major medical coverage, the Enrollment Committees of Michigan Blue Cross and Michigan Blue Shield have been at work on extended benefits coverages that will meet this market situation, while adhering to the basic Blue Cross-Blue Shield contract structures.

BLUE SHIELD CONTRACTS

	TYPE OF CONTRACT	IN-HOSPITAL MEDICAL CARE DAYS	TOTAL DAYS WITH RIDER	RENEWAL PERIOD	DAYS FOR MENTAL, NERVOUS, TB	RENEWAL PERIOD
GROUP	M-75 Group	120	365 (Rider M)	3 months between stays	30	6 months between stays
	M-75 Group Deductible	120	365 (Rider M)	3 months between stays	30	6 months between stays
	M-75 Income-Not-Certified Group	120	365 (Rider M)	3 months between stays	30	6 months between stays
GROUP CONVERSION	M-75 Group Conversion	120	Not available	3 months between stays	30	6 months between stays
	M-75 Deductible Group Conversion	120	Not available	3 months between stays	30	6 months between stays
NON-GROUP	M-75 Non-Group (under age 65)	30	Not available	3 months between stays	30	6 months between stays
	M-75 Non-Group (over age 65)	30	Not available	3 months between stays	30	6 months between stays

BLUE CROSS CONTRACTS

	TYPE OF CONTRACT	DAYS OF CARE	TOTAL DAYS WITH RIDER	RENEWAL PERIOD
GROUP	Comprehensive Hospital Group	120	365 (Rider D)	3 months between stays
	$50 Deductible Group	120	365 (Rider D)	3 months between stays
	Economy Group	30	120 or 365 (Rider EE or DE)	3 months between stays
GROUP CONVERSION	Comprehensive Hospital Group Conversion	30	Not available	3 months between stays
	$50 Deductible Group Conversion	30	Not available	3 months between stays
	Economy Group Conversion	30	Not available	3 months between stays
NON-GROUP	Non-Group (under age 65)	30	Not available	3 months between stays
	Non-Group (over age 65)	30 Ward Only	Not available	3 months between stays

NEW RIDERS TO BLUE CROSS-BLUE SHIELD

RIDER F may be added to any combination of group hospital and M-75 contracts to provide group benefits at group rates for unmarried children of 19 to 25 years of age who are dependent upon the subscriber for more than half their support.

RIDER S may be added to any combination of group hospital and M-75 contracts to provide coverage for group conversion benefits at group conversion rates to persons, regardless of age, who are dependent on the subscriber for more than half their support and who

SHIELD CONTRACTS IN BRIEF

CLASS I SERVICES: In-hospital medical care; surgery; obstetrical delivery; professional anesthesia; first aid.	CLASS II SERVICES: Technical surgical assistance; consultations; outpatient and office lab services; diagnostic and therapeutic x-ray.	OTHER DEDUCTIBLES	INCOME CERTIFIED
Service benefits for Plans A, B and C*	Member pays greater of $5 or 10% of M-75 scheduled fee*	None	Yes
Service benefits for Plans A, B and C*	Member pays greater of $5 or 10% of M-75 scheduled fee*	Greater of $10 or 20% of scheduled fee for in-hospital medical care and surgery.	Yes
Service benefits for Plans A, B and C*	Member pays greater of $5 or 10% of M-75 scheduled fee*	None	No
Service benefits for Plans A, B and C*	Member pays greater of $5 or 10% of M-75 scheduled fee*	None	No
Service benefits for Plans A, B and C*	Member pays greater of $5 or 10% of M-75 scheduled fee*	Greater of $10 or 20% of scheduled fee for in-hospital medical care and surgery.	No
Service benefits for Plans A, B and C*	Member pays greater of $5 or 10% of M-75 scheduled fee*	None	No
Service benefits for Plan A*	Member pays greater of $5 or 10% of M-75 scheduled fee*	None	No

**Participating doctors guarantee service benefits for members in Plans A, B and C if the subscriber's income is within the limit for his Plan (Plan A, $2,500; B, $5,000; C, $7,500; D, $7,500 or more), unless the member chooses a private room.*

DAYS FOR MENTAL, NERVOUS, TB	RENEWAL PERIOD	SERVICE BENEFITS	DEDUCTIBLE	MATERNITY
30	6 months between stays	Yes	None	Service benefits
30	6 months between stays	Yes, other than deductible.	First $50 of contract benefits	Service benefits
30	6 months between stays	Room services limited to $14 per day.	None	Full contract benefits.
30	Not renewable	Yes	None	Room services of $14 per day.
30	Not renewable	Yes, other than deductible.	First $50 of contract benefits	Room services of $14 per day.
30	Not renewable	Room services of $14 per day.	None	Full contract benefits
30	Not renewable	Room services of $14 per day	None	Room services of $14 per day
30	Not renewable	Yes, other than deductible.	Greater of $25 or 20% of first $500 of contract benefits.	None

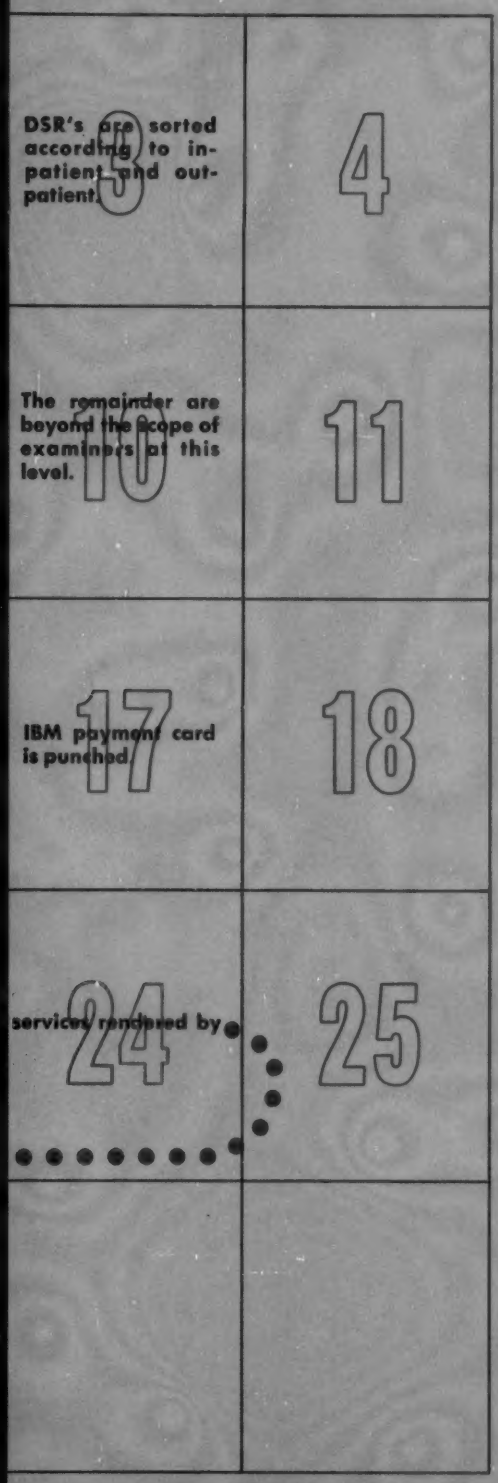
are related to the subscriber by blood or marriage, or who are members of his household.

These riders are available if the dependent qualifies as an income tax exemption and has been reported as such on the subscriber's income tax return, and if the subscriber's employer makes the payroll deduction mechanism available for the collection of subscription dues or if the group subscribers are billed directly by Blue Cross-Blue Shield (Example: enrolled members of the Michigan State Medical Society). The cost of the S or F riders will be included in the subscriber's billing.

1960 JUNE

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY
			1 Incoming mail is opened; date of receipt is stamped on each DSR.	2 IBM card is punched for each DSR for accounting purposes. DSR is checked to determine such information as whether doctor is licensed, whether he participates.
5	DSR is checked against hospital admission records or enrollment records to determine patient's eligibility for benefits. If DSR carries incorrect or incomplete information, Blue Shield corresponds with doctor or subscriber to obtain full and correct information. If DSR checks out correctly, the patient's eligibility is certified and the DSR is sent to the claims examiners.			About 70% of claims are handled routinely by Primary or Intermediate claims examiners.
12	The 30% of claims not handled by Primary or Intermediate examiners are reviewed by Senior examiners. An additional 29% are handled routinely by this group; the remaining 1% is handled by the Medical Director and his staff or is referred to the various county medical advisory committees.		15 DSR data are posted for statistical use.	16
19	20 Payment cards are accumulated for from 8 to 12 working days so that payment for up to 17 a single doctor may be accomplished with one check in one mailing.	21	22	23
26	27	28	29 Check is mailed to doctor.	30

1960



PAYING THE DOCTOR

READING TIME: 1 MINUTE, 15 SECONDS

Each working day, the mailman delivers about 8,500 Doctor's Service Reports to Michigan Blue Shield.

Thus begins a many-stepped process that ends about 30 days later with the mailing of a check covering payment for the doctor's services to Blue Shield members.

To oversimplify, the process of handling claims involves only three basic questions: 1) Is the patient eligible for benefits; 2) Is the doctor eligible for payment; 3) What is the doctor's fee. Handled individually by a single human being, the process would be short and simple—perhaps a matter of minutes.

But, multiply those few minutes by 8,500 and add such modern requirements as accounting and record-keeping, and the process grows.

But, modern business' intricate organization, its tendency to compartmentalize and to specialize, its mass-production approach to paperwork — in short, its use of complex methods to solve simple problems—pays off in the end: At Michigan Blue Shield, it takes only about 45 claims examiners to handle those 8,500 DSR's daily — as many as 500 claims per person per day.

For the sake of economy, as well as efficiency, Blue Shield accumulates approved claims so that a number of services (up to 17) for a given doctor may be paid with one check in one mailing. The savings in materials, time and postage (for Blue Shield) and in accounting and banking chores (for the doctor) are considerable.

However, not all DSR's reap the benefit of this efficient claims-processing system: About 25 per cent of DSR's come to Blue Shield bearing misinformation or too little information, resulting in time-consuming correspondence with doctors or subscribers. In these cases, payment may be delayed by as long as 90 days.

The chart at left is a graphic representation of time and sequence in the process of paying the doctor.

WHAT JOHN Q. DOESN'T KNOW HURTS YOU!

BY J. S. DoTAR, M.D.

READING TIME: 5 MINUTES, 45 SECONDS

If you think John Q. Public is naive in the field of electronics, high finance or astronomy, you haven't seen him in a hopeless struggle with the intricacies of prepayment health care plans.

I can't think of many situations in which the average person is as helpless as in his attempts to understand his benefits when receiving services in a prepayment program.

Even his annual bout with the Bureau of Internal Revenue doesn't produce the bewilderment and frustation that he experiences when wrestling with the mysteries of prepayment.

If Uncle Sam's income tax returns and procedures are too much for him, he can, and frequently does, go to a tax expert and, for a few dollars, rids himself of the problem.

True enough, if the details of his Blue Shield coverage are too much for him, he has recourse to expert advice here, too, since Blue Shield maintains a staff of trained personnel whose job is to give personal help to the subscriber with problems of his coverage.

But there's a basic difference in the two situations. John Q. is wise enough to go to the tax expert before the damage is done, not later. However, in the case of his Blue Shield coverage (or any prepayment coverage, for that matter), he is not apt to give it a thought until he has occasion to use it—after he has already blown his top at the doctor and/or Blue Shield about that "extra" charge from the doctor for a service that he thought was covered by his contract.

I assure you that if you have ever known the resentment — born of ignorance — of a confused patient in these circumstances, you need not feel that you are alone.

Why doesn't the patient know what he's entitled to? Well, I think the trouble lies in the fact that when John Q. Public gets involved with prepaid health care, he enters the (to him) esoteric worlds of 1) Prepayment and 2) Medicine, two highly special-

ized and complex fields. And the individual who is familiar with both is a rare specimen.

When an individual buys coverage from—say, Blue Shield —he does so only after receiving literature which, next to the contract itself, is about as complete a description of the benefits offered as could possibly be devised. Blue Shield, for example, realizes that it has an obligation to inform the consumer of the features of the product it offers for sale, and it expends a great deal of time, effort and money to tell him (usually in no less than 1,500 words) about the benefits for which he is contracting. Blue Shield gives him a complete rundown on the product. Blue Shield tells him what he is getting, how it works, how long it will last and how much it costs. Simple, isn't it?

Well, it would be if the product were an automobile or an automatic washer or a new home — items that are familiar to practically everyone between 10 and 100 years of age. When you tell John Q. that the car has an automatic transmission and a V-8 engine, or that the automatic washer has a temperature control and three water levels or that the new house has a dining ell and bath-and-a-half, he knows what you are talking about. Very little education is required; a mere description suffices.

But when the product is medical care, merely describing benefits doesn't do much for the purchaser because the field is so foreign to him. He doesn't know the terminology, he doesn't know medical procedures. He can't relate the doctor's actual medical procedures to his benefits unless he is taken by the hand and led through an explanation (He knows that he has filled a bottle, but does he know this as a step in a laboratory service? He knows that you've taken three X-ray films, but does he know this may be an "X-ray study" and not three individual services?).

Far beyond his depth in a world that is strange to him, and at a time when psychologically, he is at a disadvantage, he is ill-equipped, particularly when his mind is on his illness, to understand and remember what is being done to him medically and then to refer to Blue Shield literature in an attempt to learn to what degree his treatment is prepaid. In the vast majority of cases, it is too much for him.

But, with benefit of a few minutes of explanation from his doctor, he can know not only what is being done for him, but also what it probably will cost over and above the Blue Shield benefit.

Of all parties involved, the physician is in the best possible position to give the patient a pretty good idea of what the patient's liability will be in a given case because the physician has the readiest knowledge of the factors that determine that liability; that is, he knows whether or not he is a "participating physician," he knows Blue Shield benefits (or has ready access to such knowledge); he knows what his normal fee is; he knows what the Blue Shield payment is (he has a copy of the schedule of Blue Shield fees); above all, he, better than anyone else, knows what service was rendered—how, why and to what degree. With this information, the physician can give the patient a fairly close estimate of what portion of the cost of the service is to be borne by the patient.

The physician who does so performs an excellent service — not only to the patient but to his good relationship with that patient.

Most physicians will agree — this far. But it is not enough merely to make this information available to the patient only if and when he asks for it — because he probably won't ask for it. Very few patients can bring themselves to introduce the matter of finances in a conversation with the doctor. I don't know why and I haven't spoken to any motivational researchers lately, but people seem to be afraid of doctors. The opinionated, strong-minded layman who would not hesitate to question the judgment of the Deity is as a timorous child when face to face with his doctor. "You're the doctor!" is what he says and believes — in the office. But, this doesn't prevent him — in the safety of his home and in the circle of his friends — from giving vent to anger over the financial aspects of his treatment.

So much has been written on "how to keep your patients happy" that it would seem almost a bore even to talk about the subject. But, apparently, and commendably, the average physician does care about good relationships with his patients, and so it's worth giving additional thought to the subject.

To avoid being accused of a singular naivete, I hasten to point out that the practice of giving the patient a little advance warning of any out-of-pocket expenses that he may have to bear for medical services is no magic key to *perfect* patient-doctor relationships. But, I insist that such a practice will in most cases, maintain and improve the feeling that a patient has for his doctor.

Furthermore (and don't underestimate this value), even if

such a policy does nothing to improve a particular patient's attitude toward his doctor, it will at least remove some handy ammunition that the patient may seek if his real complaint is of the variety that he can't even admit to himself (he doesn't like your office manner or the way you part your hair or the magazines in your waiting room, or through some incredible process of logic, he blames you because he got sick). At least he won't be able to paint you as an ogre who lulled him into a sense of security and then shattered his serenity with a big bill.

The lesson seems clear. A patient who knows in advance what his out-of-pocket expenses are going to be, is obviously apt to be better prepared for, and less shocked by, a statement from the doctor for service not fully covered or not covered at all by Blue Shield.

Now, I do not propose that it be the physician's responsibility to explain an entire prepayment program to a patient. Obviously, the physician cannot and ought not permit himself to be imposed on in this way. But what he (or, alternately, a qualified medical assistant) can do is to take just a minute or two to let the patient know what medical services are being performed in his particular case and the degree to which those specific medical services are covered by prepayment.

This type of help for the patient heads off much of the confusion, disappointment, and resentment that otherwise might well develop from a lack of understanding.

I think that you'll find that even a little of this kind of help will go a long way toward making your patient happy as well as healthy.

BLUE SHIELD PROFESSIONAL RELATIONS CONFERENCE

READING TIME: 2 MINUTES, 45 SECONDS

Speaking at the annual Blue Shield Professional Relations Conference in Chicago, MALCOLM L. DENISE, Vice-President-Labor Relations, Ford Motor Company, asserted that as employers and industrial citizens of the community, business management today has an important stake in hospital and medical care. He said that Blue Shield service-type programs represent the medical profession's strongest bulwark against the intrusion of government or powerful private economic groups in the field of medical practice.

Mr. Denise expressed his faith "in voluntary programs and the ability of the professions and community organizations involved to fulfill the needs of our people. I am encouraged in this faith by the increasingly abundant evidence that our doctors, our hospitals and our voluntary community organizations are conscious of the problems and are aware of their responsibilities and means of meeting them. Given this awareness and attitude, I feel confident that they will be met within the framework of our free institutions."

DONALD STUBBS, M.D., Chairman of the Board of Directors, Blue Shield Medical Care Plans, discussed the dual function of a Blue Shield Plan's governing board. Dr. Stubbs said that one function is to preserve and enlarge the plan as the economic vehicle intended to protect private enterprise by voluntary prepayment. The other, he said, is "to keep physicians at the management level of this system of prepayment by their trusteeship purchased through the commitment of individual doctors and of the medical profession." Said Dr. Stubbs: "Only if Blue Shield retains and enlarges the physician commitment and expands and strengthens this keystone of the prepayment movement, only then can we have our best chance to save our free profession and to keep our free profession in a free society."

BARRON K. GRIER, legal consultant to Blue Shield Medical Care Plans and a member of the law firm of Miller and

Chevalier, Washington, D.C., urged all Blue Shield Plans to continue to work together in combatting Forand-type legislation. "I think that great things have been accomplished," said Mr. Grier, "but I don't believe we can look back. I think we have to look at the future and that even greater things can be accomplished if Blue Shield Plans can go down the road together as full partners in accomplishing that fact."

Speaking of the future of voluntary prepayment, Mr. Grier said: "If we can provide more health care for more people, both young and old, then the future is bright. If we cannot, then I think the pressure for the government to step in and do so will be irresistible and we will begin to die on the vine."

JOHN B. RECKLESS, M.D., a resident at Duke University Medical Center and a former practitioner under the British National Health Service, said that the medical profession in Britain was unable to forestall government medicine in Britain because the profession lacked cohesive organization and public support. He said that lack of an organization to meet the government program on the same "ruthless footing" enabled the government to employ divide-and-conquer tactics as its primary weapon against doctors.

Dr. Reckless said that the threat of government medicine definitely exists in the United States, but added: "I think you have in prepayment medical plans an effective challenge to government-sponsored health insurance." He said Blue Shield Plans especially represented "one answer to the situation which you have here in America."

THOMAS C. PATON, Michigan Blue Shield's Director of Professional Relations, also called attention to the growing threat of government medicine, and said that Blue Shield Plans and their Professional Relations staffs must share the responsibility for combatting it.

Said Paton: "We must give medicine all the help we can in terms of providing information on medical economics and in terms of evaluating that information. And we must give medicine the full benefit of our knowledge and our honest advice, telling them what we believe to be true and right, and not necessarily what we think medicine would like to hear. If we fail to live up to this responsibility, medicine may well be swallowed by government."

MICHIGAN MEDICAL SERVICE

PAYMENTS FOR SERVICES TO SUBSCRIBERS BY RESIDENCE OF DOCTORS RENDERING SERVICE FROM MARCH 1, 1940 THROUGH DECEMBER 31, 1959

1.	Alcona	$ 71,579.25	.02%
2.	Alger	61,867.00	.02
3.	Allegan	727,853.34	.19
4.	Alpena	1,608,164.81	.43
5.	Antrim	62,179.25	.02
6.	Arenac	194,959.65	.05
7.	Baraga	258,663.40	.07
8.	Barry	315,844.40	.08
9.	Bay	5,614,085.39	1.48
10.	Benzie	177,824.33	.05
11.	Berrien	2,368,915.64	.63
12.	Branch	987,885.63	.26
13.	Calhoun	3,636,068.98	.96
14.	Cass	146,759.38	.04
15.	Charlevoix	402,519.85	.11
16.	Cheboygan	621,750.33	.16
17.	Chippewa	2,024,072.32	.54
18.	Clare	87,648.72	.02
19.	Clinton	1,262,133.46	.33
20.	Crawford	286,107.11	.08
21.	Delta	655,675.75	.17
22.	Dickinson	553,776.86	.15
23.	Eaton	864,329.05	.23
24.	Emmett	1,754,472.42	.46
25.	Genesee	24,822,639.15	6.57
26.	Gladwin	219,937.19	.06
27.	Gogebic	340,113.42	.09
28.	Grand Traverse	2,298,767.74	.61
29.	Gratiot	725,666.34	.19
30.	Hillsdale	880,252.43	.23
31.	Houghton	834,909.42	.22
32.	Huron	906,055.05	.24
33.	Ingham	12,540,368.81	3.32
34.	Ionia	1,114,919.30	.29
35.	Iosco	393,419.88	.10
36.	Iron	110,781.00	.03
37.	Isabella	1,258,626.49	.33
38.	Jackson	2,324,020.68	.61
39.	Kalamazoo	4,281,067.69	1.13
40.	Kalkaska	26,132.00	.01
41.	Kent	14,412,487.43	3.81
42.	Keweenaw	2,900.50	
43.	Lake	8,923.00	
44.	Lapeer	1,064,261.88	.28
45.	Leelanau	195,004.96	.05
46.	Lenawee	1,398,736.10	.37
47.	Livingston	$ 673,546.40	.18%
48.	Luce	237,579.25	.06
49.	Mackinac	55,932.88	.01
50.	Macomb	6,193,977.16	1.64
51.	Manistee	284,173.78	.08
52.	Marquette	1,501,453.10	.40
53.	Mason	425,307.85	.11
54.	Mecosta	418,559.23	.11
55.	Menominee	327,633.80	.09
56.	Midland	202,980.08	.05
57.	Missaukee	236,864.13	.06
58.	Monroe	1,273,834.96	.34
59.	Montcalm	838,417.84	.22
60.	Montmorency	16,600.50	
61.	Muskegon	2,506,709.58	.66
62.	Newago	294,316.62	.08
63.	Oakland	21,844,932.65	5.78
64.	Oceana	456,484.51	.12
65.	Ogemaw	487,590.93	.13
66.	Ontonagon	291,150.30	.08
67.	Osceola	416,309.64	.11
68.	Oscoda	1,847.00	
69.	Otsego	260,055.95	.07
70.	Ottawa	1,620,633.48	.43
71.	Presque Isle	419,911.60	.11
72.	Roscommon	40,900.00	.01
73.	Saginaw	11,287,218.63	2.99
74.	St. Clair	4,183,230.07	1.11
75.	St. Joseph	607,799.60	.16
76.	Sanilac	532,760.61	.14
77.	Schoolcraft	276,458.00	.07
78.	Shiawassee	2,337,702.25	.62
79.	Tuscola	939,724.29	.25
80.	Van Buren	1,338,443.68	.36
81.	Washtenaw	13,867,789.91	3.67
82.	Wayne	156,048,604.87	41.28
83.	Wexford	938,107.63	.25
	Total	$328,581,669.54	86.92
	Total Michigan M.D.s	$328,581,669.54	86.92
	Out-of-State Doctors and Unclassified	8,677,637.98	2.29
	Paid to Osteopaths	40,809,394.15	10.79
	TOTAL	$378,068,701.67	100.00

A Defense of Conservative Treatment for Acute Cholecystitis

David McCubbrey, M.D.
E. Thurston Thieme, M.D. F.A.C.S.
Ann Arbor, Michigan

THE CHOICE of treatment for acute cholecystitis has and still does provide reason for discussion. Immediate operation presumes a correct but frequently unconfirmed diagnosis and accepts the dangers of non-elective operation while offering a possible reduction in hospital stay. Conservative treatment with delayed operation accepts the dangers of perforation of the gallbladder and pericholecystic abscess, while offering possible surgery of election, after completion of diagnostic studies and thorough evaluation and preparation of the patient for operation. Which method of treatment provides the best care for the patient is still open to discussion. This statement is particularly true if it is realized that methods of treatment giving excellent results at one institution may be harmful or inappropriate if applied indiscriminately to another hospital.

TABLE I. ADMISSIONS FOR ACUTE CHOLECYSTITIS
345 Cases

Surgery Performed this Admission	191 Cases 9 Deaths 4.7%
No Surgery Performed—Discharged	154 Cases No Deaths

Patient Refused Surgery	Other Disease Paramount	Normal X-Rays	Medical Care	To Return For Surgery
14	41	21	58	20
Returned For Surgery				
4	7	0	24	12

47 patients returned for surgery—30%.

Conservative treatment has been the policy at St. Joseph Mercy Hospital in Ann Arbor for many years. Although during this study there were cases not energetically treated, surgical consultation was obtained for all problem cases and it can be stated that no patient needing treatment for acute cholecystitis languished or died on the medical service. All patients with a history, physical examination and laboratory data sufficient to require treatment for acute cholecystitis were considered to have acute cholecystitis and so are included in the series to be reported. None were treated by "immediate, prompt, or early surgery" as meaning surgery done as quickly as the patient's condition would permit. Therefore, treatment was conservative in all cases, meaning operation was delayed if possible until the disease was quiescent and the indicated diagnostic studies completed. The results of this policy are presented as a defense for conservative treatment with the hope that organized community hospitals will reconsider its benefits.

TABLE II. EMERGENCY ADMISSIONS FOR ACUTE CHOLECYSTITIS—SURGERY PERFORMED
191 Cases

Operation	Cholecystectomy	Deaths	Cholecystostomy	Deaths
Elective	121	1	5	0
Urgent	33	1	16	1
Emergency	5	1	11	5
Totals	159	3 or 1.9%	32	6 or 18.7%

Material and Results

During the five year period 1952 through 1956, 345 patients were treated conservatively for acute cholecystitis. Of this number, 154 or 44.3 per cent were discharged without surgery being performed. The reasons for discharge are listed in Table I. The possible impact of immediate operation on this group cannot be stated except that the mortality could not have been lower as there were no deaths. Undoubtedly an aggressive attitude toward immediate operation could have led many of these patients to operation within forty-eight to seventy-two hours. In contrast, conservative treatment provided restraint for the surgeon and a better evaluation for the patient.

An operation was performed on 191 patients during their hospitalization. Table II summarizes the operations performed. Elective surgery followed successful

Presented at the meeting of the Michigan Chapter of the American College of Surgeons in Detroit, March 10, 1959.
From Surgical Service, St. Joseph Mercy Hospital, Ann Arbor, Michigan.

conservative treatment in 126 cases with one death, considered due to a ruptured dissecting aneurysm of the abdominal aorta occurring on the sixth postoperative day. Five cholecystostomies were done, therefore, the cholecystostomy rate was 4 per cent.

aside from progressive deterioration of an aged patient. The twenty-seven patients with unsatisfactory courses are actually the only patients whose disease was uncontrolled by conservative means. Of the six deaths in this group, three patients were operated upon within

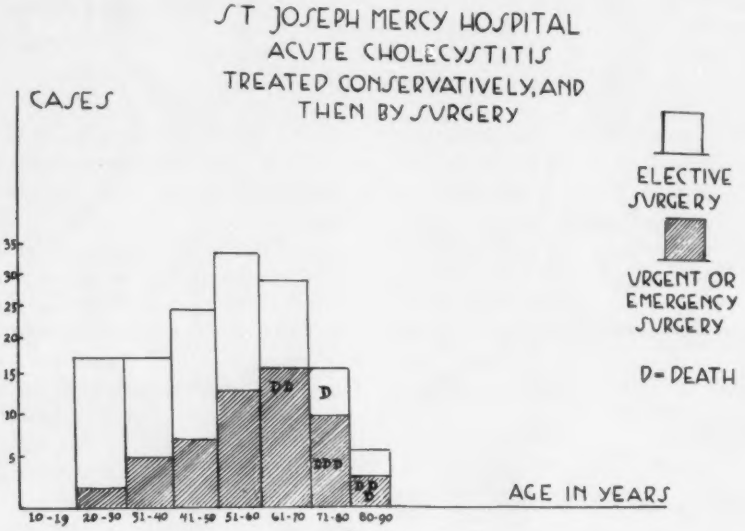


Fig. 1.

The remaining sixty-five patients required urgent or emergency operation during the course of their treatment. This group has been labeled the price or risk of conservative treatment. Eighty per cent of the patients in this group were over fifty years of age. There were eight deaths and a cholecystostomy rate of 40 per cent. The high cholecystostomy rate is indicative of the severity of the disease in this group of patients and is a result of the best judgment of the surgeon at the time of operation in this predominately aged and poor risk group of patients.

The reasons for urgent or emergency operation are tabulated in Table III. Those with continuing jaundice represent failure to relieve obstruction of the common duct. There were no deaths in this group indicating good conservative management. The second group presents the problem of a delicate balance between the cholecystic disease and the clinical condition of the patient. The single death in this group was from a sudden pulmonary embolism on the 11th postoperative day. Status quo unchanged means that the cholecystic disease was controlled at a safe level but was unsatisfactory clinically. The death here was in an eighty-two-year-old diabetic on the 30th postoperative day, the cause for which was undetermined

TABLE III. REASONS FOR URGENT OR EMERGENCY SURGERY IN 65 OF 345 CASES OF ACUTE CHOLECYSTITIS

Continuing Jaundice	Best Judgment of Surgeon	Status Quo Unchanged	Course Unsatisfactory
12 Cases No Deaths	11 Cases 1 Death	15 Cases 1 Death	27 Cases 6 Deaths

seventy-two hours, and a fourth on the fourth hospital day. The causes of death in those patients with autopsy were necrotizing pancreatitis, right heart failure, and pulmonary embolism. The three deaths without autopsy were considered to be due to cardiac arrest occurring at the termination of operation, myocardial infarction with pulmonary atelectasis, and a "liver death," with deepening jaundice and a rising NPN.

Glenn,[1] in a survey of the causes of death following gallbladder surgery, noted a sharp drop in shock, infection, and hemorrhage as a cause of death, but an increase of cardiovascular and pulmonary deaths was found. The drop in infection was attributed to the elimination of the hazard of perforation of the gallbladder by a policy of immediate surgery for acute cholecystitis. In this series, perforation of the gall-

bladder was seen four times and pericholecystic abscess six times with no direct effect on the mortality. Therefore, these possible complications do not seem valid arguments for immediate operation. Also, we doubt that immediate operation will reduce the mortality in acute cholecystitis since four of our deaths were operated upon within seventy-two hours and a fifth on the fourth hospital day. The problem of surgery in the aged patient is illustrated in Figure 1. The causes of death are those of any surgery in the aged patient.

TABLE IV. COMMON DUCT EXPLORATION

Surgery for Chronic Gall Bladder Disease		Surgery after Admission for Acute Cholecystitis	
Cholecystectomy	Common Duct Exploration	Cholecystectomy	Common Duct Exploration
407	104 or 25%	159	66 or 41%
Stones recovered	16 or 15%	Stones recovered	33 or 50%

Coller[2] has stated that it is unwise to persist in conservative treatment for acute cholecystitis for more than forty-eight hours when it is apparent that the patient is not responding to treatment, and we would wholeheartedly agree. In this series, however, prolonged conservative treatment cannot be shown to be the factor explaining the mortality. We should like to emphasize the beneficial results of elective cholecystectomy for the patient with known gallbladder disease, but we strongly doubt that a policy of immediate operation for the aged and poor risk patient with acute cholecystitis will alter the high mortality in this group of patients.

Many authors have emphasized the danger of common duct damage during surgery for acute cholecystitis. Our experience with common duct exploration is presented in Table IV. Twenty-four of the cases, or 36 per cent of the common ducts explored, were in the urgent or emergency group. The high rate of positive exploration in the acute group, 50 per cent, in contrast to the chronic group, 15 per cent, indicates that the less urgent indications for common duct exploration were ignored while operating in the presence of acute cholecystitis. Seven of the patients undergoing common duct exploration required re-operation for retained common duct stones. The overall incidence of common duct stones in the entire group of 345 patients was 16.7 per cent, or approximately one patient out of six. The common duct was damaged on one occasion, but this was immediately recognized and repaired. We know of no biliary cripples created in this series of patients. In addition, anomalies of the biliary tree were recognized in six cases and no damage done.

Pathologic examination in the operative cases confirmed the diagnosis of acute cholecystitis in all cases with only two exceptions in which chronic low grade cholecystitis was present. Cholelithiasis was present in all but five operative cases.

Discussion

The conservative treatment of acute cholecystitis, meaning the proper use of gastric suction, intravenous fluids, antispasmodics and antibiotics, has little glamor and few backers in contrast to immediate surgery which is popular and advocated as a principle for all surgical services. We have endeavored to show that conservative treatment can produce acceptable results which stand comparison with the results of immediate operation. Immediate operation as a policy for the average community hospital, where the majority of the gallbladder surgery in this country is done, could lead to much ill-advised surgery. It is true that some surgeons of outstanding ability could apply the principles of immediate operation to their own practice with success, but they must also bear the responsibility for their imitators. Conservative treatment offers restraint to the surgeon, a better medical evaluation for the patient, and acceptable results. Gallbladder disease can be confirmed by x-ray, and diseases such as acute pancreatitis, acute hepatitis, and myocardial infarction, in which operation is contraindicated, can be ruled out. We urge reconsideration of the advantages of conservative treatment for the average community hospital where clinical material is not controlled on services as in a large teaching hospital.

Summary

1. 345 cases of acute cholecystitis treated conservatively have been presented. The mortality for the series was 2.6 per cent, the operative mortality was 4.7 per cent.

2. The disease was controlled in 280 patients or 81.5 per cent, leading to discharge without operation in 154 and elective operation in 126 with one death. Thirty per cent of those discharged without operation subsequently returned for operation.

3. Urgent or emergency operation was required during the course of treatment in sixty-five cases. The reasons for urgent or emergency operations were discussed.

4. A review of the deaths indicated that the mortality was related to surgery in the aged patient rather

than complications of prolonged conservative treatment for acute cholecystitis.

5. The dangers of immediate operation for the average community hospital were discussed and conservative treatment proposed as a restraint to the average surgeon and as a means of obtaining a better medical evaluation for the patient.

6. A policy of conservative treatment will give good results if vigorously and intelligently applied.

Summary of Discussion

L. S. FALLIS, M.D., Henry Ford Hospital: In the early days of my surgical career, I followed a policy of immediate operation for acute cholecystitis since I received my training from men who believed in this method of treatment. A survey done at Henry Ford Hospital several years ago of the results of a policy of immediate operation convinced me that best results are obtained in patients who have conservative treatment and delayed operation, and I have followed that policy since. Good results can be obtained with either method of treatment in the younger patients with acute cholecystitis; the problem as presented today is in the older poor risk patient, and we feel they are best served with conservative management with the reservation that impending gangrene or perforation must be carefully watched for and treated as any other surgical emergency. I believe that the surgeons of this state owe Dr. Coller a great debt for his wisdom in advocating conservative treatment for this disease over these many years.

In our study we recognized that the diagnosis of acute cholecystitis can be made in three ways: there is the clinical diagnosis, made at the bedside, the surgical diagnosis, made at the operating table, and the pathologic diagnosis. I would like to know the criteria used by Dr. McCubbrey for the diagnosis of acute cholecystitis in this series.

DR. McCUBBREY: We recognize that there can be a great disparity between the clinical, operative, and pathologic diagnosis of acute cholecystitis. Any series reporting on conservative treatment must, however, rely solely on clinical diagnoses. Previous series reported in the literature have set up certain rigid criteria applying to the physical examination or laboratory data before accepting the diagnosis of acute cholecystitis. It was our opinion, however, that no rigid criteria should be set up, but that the total evaluation of the patient's history, physical examination, laboratory data, and clinical course should be the only criteria since it is well recognized that a very serious cholecystitis can exist with little in the way of physical findings, temperature elevation, or leukocytosis. This is one of the arguments of those who advocate immediate operation, that perforation of the gallbladder can occur with little warning. Accordingly, we accepted those patients whose total evaluation warranted treatment for acute cholecystitis, and at least the patients operated upon had excellent correlation with the pathologic findings.

In conclusion, we would like to emphasize that what we are advocating is active, vigorous, conservative management with no unnecessary delay in operation in the event that the patient fails to respond promptly to treatment. We do not believe that merely "watching" a patient constitutes good conservative treatment.

References

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2. Buxton, R. W., Ray, D. K., and Coller, F. A.: Acute cholecystitis. J.A.M.A., 146:301, 1951.

X-Ray "Beauty Contest" Called Risky by Expert

Plans of chiropractors to x-ray pretty girls to choose a "posture queen" were denounced in April by the head of the radiology department of Wayne State University medical college as a "potential hazard."

James E. Lofstrom, M.D., declared that "any unnecessary radiation is to be avoided."

Doctor Lofstrom commented on plans of the Michigan Academy of Chiropractice for its sixth "beauty contest" in connection with its annual meeting in Detroit.

Spinal x-ray pictures were made to help select the "posture queen."

"They should be able to judge the shape of the spine by the exterior appearance of the young woman," Professor Lofstrom said.

"Radiologists attempt to confine x-ray exposure as locally as possible. This x-raying of the spine will mean exposure of the gonads to unnecessary radiation and the effect of this is regarded as a potential hazard."

The Changing Image of Medical Care

Harry J. Loynd
Detroit, Michigan

AN INVITATION to speak on the program of this distinguished Institute is an honor. When your invitation was extended to me, I was most pleased to accept. I was requested to deliver the pharmaceutical lecture, and, I presume, it is expected that I should talk about drugs, or at least about the drug business and the pharmaceutical profession. With your permission, I shall utilize my time on this program for a somewhat different purpose, and leave the assignment of telling you about our products to our highly capable detail staff and to your own retail pharmacists.

The subject I have selected for my remarks, "The Changing Image of Medical Care," was chosen because I believe that it is something we should recognize and a subject which is, or should be, of deep concern to us. I would like to explore this topic with you.

The public's concept of adequate and proper medical care is changing, in some respects for the better, in others for the worse. They appreciate the ministrations of the medical profession, but not always its ministry.

There are, of course, many reasons for this, not the least of which is the avidity with which all news media respond to medical news, both good and bad. Perhaps, too, in light of this interest, the traditional professional reserve and total devotion of the physician to his strictly professional duties, has made it appear that he resists any change in his environment.

Dr. Frank Slaughter, as reported in the *Journal of the Florida Medical Association*, as part of a talk entitled, "The Physician in a Troubled World," has this to say, "Perhaps the most deadly form of conformity, as applied to doctors, is the widespread belief that a man of medicine must be isolated from the affairs of the world. Medicine must always deal not simply with disease but with the whole man in relationship to society, for man cannot long remain healthy in an unhealthy society. The great men of medicine have all been outstanding as intellectuals, as philosophers, or in other ways. One needs only to read the writings of Sir William Osler and Oliver Wendell Holmes to realize this truth once again. Even Rudolf Virchow, father of cellular pathology, left his microscope long enough to write: 'People must feel that they belong together, not on account of a common ancestry, which they perhaps do not have . . . but on account of a spirit in which they live together.' What better credo could be laid down in these troubled times when the nations of the world must stand together for peace, or fall separately into oblivion?"

Since you have been kind enough to invite me, a non-physician, to talk on this program, I would like to immediately establish a common ground for discussion and to emphasize that I have no feeling of hesitancy in making a few observations or in mentioning some problems which, in my opinion, should be considered by the medical profession. Let me explain that my lack of trepidation in this assignment is due to the fact that the ethical pharmaceutical manufacturers, whom I represent, are, today, so intimately and directly concerned with the problems of medicine and their solution, that we could not possibly place ourselves in a position of a totally disinterested observer, even if we wished to do so. Our success and our future survival are totally dependent upon the well-being of the private practice of medicine. We have a proprietary interest in any problem or any program of the medical profession. We must, therefore, have and maintain, a complete familiarity with medical practice and a continuing determination to further everything that is good for our democratic

THE AUTHOR
Harry J. Loynd

Mr. Loynd is President of Parke, Davis & Company.

concept of medical care, and to oppose every effort to dilute or destroy it. In short, I would like to have you consider my remarks as those of an "inside-outsider," and of one who is deeply conscious of the fact that your problems are, in part, our concern as well.

I would like also to eliminate any impression which my introduction as a "pharmaceutical lecturer" might have given. It is not my intention to lecture this group of practicing physicians as a professor would before a group of students. Rather, I would ask that you consider my remarks as those of a professional colleague who is just as deeply concerned with the problems of medicine as are any of you, and who is, in fact, perhaps even more so when you consider the point I have already made that the survival of the ethical pharmaceutical manufacturing industry is totally dependent on your survival as an independent element of the free enterprise system.

I would ask that you gentlemen consider that some of the problems of the pharmaceutical manufacturers are also your problems, and that the way in which both your profession and ours conduct their activities are mutually important and mutually contributory. Of more immediate concern is the fact that the public is immensely interested in our business and your profession and have been inclined, particularly in recent years, to take an almost intrusive interest in us.

Today, health, or the lack of it, which we call disease, is no longer entirely a personal thing, it is not even an insular thing. Health is everybody's problem and everybody's business—and there is getting to be an astronomical number of "everybodies." In 1957, the world population was estimated as almost three billion persons and in 1958 were added another forty-seven million. In one year, the total world population was increased by more people than the populations of *all* the New England states plus those of New York, New Jersey, Pennsylvania and Maryland. Further, it is expected that within the next twenty years the total population of our world will increase to over four billion people. Since this population explosion is by no means confined to far away foreign areas, we must be more than casually interested and concerned. As colleagues in the business of medical care, we must recognize the immense problems this population bulge will create for our health team in the future. We in the pharmaceutical manufacturing industry have tried to recognize this huge population increase by the expansion of our research and production facilities, with particular reference to our world-wide operations. We feel that the medical problems of the rest of the world are of more than academic interest to us in this country and, in fact, that expansion of our facilities to the other continents might well be considered as a constructive kind of statesmanship. In the long run, drugs which cure or suppress malaria in India or control yaws in Africa may prove to be more decisive weapons against tyranny than intercontinental ballistic missiles.

As population grows, so will increase the already widespread interest in medical care and in therapy itself. We have seen, in the past few years, a revolution in the public reporting of medical and scientific progress throughout the world. Whether we approve or not, the fact remains that all peoples have developed an almost insatiable appetite for medical information. News media have discovered that the reporting of such information is of greater reader interest than almost any other subject. This intense concentration of attention on our professions has been, perhaps, a blessing in disguise. We in the pharmaceutical manufacturing industry frequently have been embarrassed by premature publicity of our research efforts. The medical profession has been equally disturbed by public demands for medications which have not even had satisfactory clinical trial before the public knows more about them than do you. Perhaps, however, we should not be too disturbed by this somewhat premature reporting of medical advances if we consider the public's appetite for this type of information as an indication of their earnest desire for better medication and greater disease prevention. Rather, we should take the necessary steps to see to it that the information the public receives is accurate and free from exaggerated or unwarranted claims. Unfortunately, we have not as yet done very much to insure this type of accurate medical reporting or to eliminate sensationalism and wishful thinking from medical information furnished to, or acquired by, public reporters. We tend to scream in anguish over exaggerated medical articles in public journals but we, too often, do little or nothing to insure the accuracy of such reports. In fact, we sometimes try to cloak ourselves in an "ivory tower" atmosphere of mystery and erudition which is illogical. We are both living in a medical "goldfish bowl," in an age when everything an industry or profession does is open to immediate public reporting and opinion. We are subject to scrutiny which can rapidly become highly critical if great care is not exercised to insure that the public understands our activities. In this connection, I am reminded of an article which appeared in a recent issue of *Medical Economics*, entitled, "You're Not

Running a Private Concession!" In this article, Dr. Norton S. Brown, president of the New York County Medical Society, states that, "While medicine used to be entirely a private enterprise, it is changing to the character of a public utility." He says, "Medicine used to be a private concession operated by doctors for doctors. It is now becoming a public utility operated by doctors in cooperation with other segments of society."

It is entirely possible that the pharmaceutical industry is also assuming some characteristics of a public utility, at least to the extent that is evidenced by public interest in our products and in our research program, and by the attention devoted to us by political and governmental groups.

Here again perhaps we should be complimented, rather than frightened, by this sometimes irritating attention. It indicates that medical care is a vital public issue, and, therefore, deserving of political attention as a factor which will influence voters toward those politicians who make use of its obvious position in the public consciousness.

The American medical profession, and its ancillary services, including pharmaceutical manufacturers, have set a standard for the world. Through the achievements of our research programs, and the capacity of our drug industry, we have demonstrated our ability to successfully control disease and nutritional problems which were historically accepted as destroyers of populations. The rest of the world has seen our success and wants to share it. This is a good thing, and is our responsibility and our opportunity to make not only a medical, but a political contribution to the world in which we live.

Research

We in this industry are proud of our research contributions and of the way in which they have assisted the physician in his efforts to treat or prevent disease. We like to think that we both have contributed toward a longer and healthier life span for the world's people. Perhaps we have helped the public to achieve a confidence that most major diseases can be adequately controlled with existing knowledge and medicines. Together we have probably maneuvered ourselves into the position which was recently expressed by a prominent clinician discussing medical advances. He said that we have made so many advances in the prevention or cure of previously epidemic infections that we are in the anomalous position of saving people from so many of the diseases which decimated populations in the past, that they are now candidates for diseases which were previously of small statistical importance and which were largely ignored in previous medical care programs. We quite literally prevent their illness or death from some infections so they may become victims of other and as yet unconquered ones. There are many more mountains on our medical horizon and there is little probability that our research efforts can or should be curtailed in the future. We still have a big job to do in medical research.

We also have one in a seemingly unrelated but equally vital field—public relations. While our ability to do a medical job of prevention and cure has given us the stature of a giant, our image, in the mind of the public, has changed. Too many of them are being told that our private medical system is an avaricious and selfish one; in short, that it's about time to cut it down to size and control it by regimentation and bureaucratic supervision. The public gratefully, even if sometimes indifferently, accepts the vastly improved service we offer but they read that it costs too much.

How has this changing image developed, and why? A generation or less ago the relation between a physician and his patient was a highly personal one in which little or no outside influence would, or indeed was permitted to intrude. There was little reason for the physician to explain his medical or economic procedures to the patient. I know that you will agree that the attitude of the public toward their medical advisors has changed. It is now one to which some physicians find it difficult to adjust and one which is resented by others and indeed baffling to some.

The physician these days is not treating just the affected patient on a personal basis, but is guiding whole family units—mates, parents and siblings—to mold environments where stressful stimuli as causative or contributory agents are effectively reduced.

In this changing image, the trend is toward a greater institutional character in medicine. It is a worldwide trend. In all countries, regardless of differing economic or political systems, medicine is changing from a private relationship between two individuals into a medico-social institution or, more precisely, into part of a great network of social welfare institutions which is making it possible to shift the emphasis from periodic cures to continuous health maintenance.

Also, the 1959 physician is dealing with a much more "hep," sophisticated and demanding clientele—the group brought up in the past decade on popular magazines accepted by them as authoritative "medical journals."

After reading some of the current comments in lay journals, it is rather disheartening to reflect that we,

who were so recently eulogized as the source of life-saving miracle drugs, are now pilloried as profiteers. And it's plain by the news from Capitol Hill that such criticism is not limited to magazines and newspapers, but is relished as a grassroots political issue.

It is said that there are almost two million persons who owe their lives to new drug discoveries of the past fifteen years. The fact that some of these same persons are now criticizing the industry and the profession that saved their lives is not base ingratitude, but rather simply ignorance of the facts. Again, an example of the need for a sound public relations program.

All of us, physicians, pharmacists and manufacturers, are partners sharing a common interest in serving the health needs of the patient. The image they form of us should be of mutual concern. We should all work together to demonstrate our rightful position, because, in this changing image of medical care, health is indeed everybody's business.

We must recognize that it is our job to educate the public to some phases of medical care which have previously been highly privileged and therefore undiscussed and unpublicized. We must lead the public to understand that medicine is an art and a science which is not, and never will be, a completely exact, formalized, or mechanical procedure. We must teach them to understand that experimentation and risk is always involved. We must do these things, and, yet, at the same time, impress them with the high quality of private medical care and the desirability of its administration by private practitioners. We must welcome accurate and factual reporting and we must justify our procedures, and the price we charge for them.

I would like to take a moment to discuss this element of medical care—its cost—a subject which has received an enormous amount of publicity, much of it critical and detrimental. It is alleged in the public press that medical care is too expensive and, in support of this accusation, we see articles which state that the physician makes too much money, that hospitals grossly over-charge their patients, and that drug products are over-priced to the excessive profit of the producer. It is not my intention to launch into a long explanation or defense of the economics of drug product pricing, or of medical care itself, other than to say that here, indeed, is one area where we have failed to give the public our side of the story. The alleged facts that have been aired by the public press are sometimes warped, exaggerated or illogical conclusions by writers who are antagonistic or who are simply appealing to an apparent appetite for sensationalism. Most newspaper and magazine writers, on the other hand, are sympathetic with the public relations problems of medicine, and many of them have done us signal service in presenting the true facts to the public. For example, in our industry, we have found that, if you give the press the complete facts, both technical and economic, their reports are accurate, well-written and sympathetic. The good scientific writer resents his undisciplined colleague just as much as we do a maverick in our own ranks.

We have not done a very good job of explaining the cost of modern medical care in the light of what the average person gets for their medical care dollar. Certainly, modern medical care, and its auxiliary services of hospitalization and drugs, cost more per unit than they did in previous generations. But what do they get for their money? In my opinion, today's medical care, is the biggest service and commodity bargain that any person will ever buy in his entire lifetime. But we have not convinced the public of this fact.

If we are to avoid further federal legislation, spurred by public misunderstanding, the health team must explore all avenues and join together to support a mutually beneficial program of public information and communication based on nothing but facts—in short, a good sound public relations program. It is important if we are to keep medicine in the hands of the medical practitioner and not hand it, by default, to some government agency or bureau.

A recent survey of medical and pharmaceutical associations throughout the country would indicate that there is much confusion and uncertainty as to just what they should do on the subject of public relations. In fact, the survey revealed that there is almost an even split between those who feel it desirable to deal directly with qualified science writers of the press and those who feel that it is not in the public's interest to report on medical activities. Most of the associations have public relations committees but in many instances their relations with the lay press rather resemble two strange bulldogs glaring and snarling at each other. It is obvious that there is little agreement on a basic policy in dealing with the press, and it is apparent that the physician and the pharmaceutical manufacturer both need and are looking forward to the day when a clearer understanding of public relations responsibilities will lead to more productive public relations efforts. The results—a better informed and more accurately informed public.

As time goes on, the long-term interests of the

medical profession, the ethical pharmaceutical industry, and the general public are going to become increasingly identified. Moreover, with the passage of time, the welfare of each group, the fate of each group, is going to rest increasingly in the others' hands. It is of paramount importance, therefore, that each of the three groups learn to understand and appreciate the problems and viewpoint of the other two. Only through mutual knowledge and understanding can each group be led to sacrifice its own short-term interests for the long-term common good, so necessary now that health is becoming everybody's business.

Let's face it. We are going to have public attention, public relations, whether we like it or not. Let's make sure it is good relations and favorable attention.

We don't need to impress people that we are skilled, that we are capable, that we are "ten feet tall." We need, rather, to demonstrate that we are wide in our understanding, sincere in our desire that everyone, regardless of their economic level, benefit from our joint efforts, that the mystery of the medicine man is no longer part of our image, but that its removal reveals a bigger and more cosmopolitan profession, and one which needs, and deserves, unreserved public approval and support.

Our external communications are a problem, but I believe we have an internal one as well. As I see it, today's physician finds, because of the tremendous increase in medical knowledge, that his period of training has no end, either in time or cost. The pressures on him to specialize have increased to the point where, even if he decides to go into general practice, he feels the need to pass his boards to become a "general specialist." The personal pressures on him, especially the demands on his personal time, have increased to the point where he cannot possibly accomplish all of the things he feels he should do: see one to two hundred patients per week; read ten to fifteen general and special medical journals per month; see ten to fifteen detail men a week; read several hundred pieces of direct mail each week; attend hospital staff and county medical society meetings; attend special seminars; attend state and national medical conventions, *et cetera*. All this besides sparing a little time for the demands on him as a human being, for a wife, children, and a little civic and social life. So it is not surprising that he may neglect the intangibles of his public socio-economic image.

Can the drug manufacturers help with this problem? The answer is "yes." We have already taken an active role in the job of creating a good public image for medicine. My own company, for example, has carried on, for nearly thirty years, an extensive advertising campaign, not on our products, but on the behalf of the medical profession. We have urged the public to "See Your Doctor;" we have discussed "The Cost Of Medical Care," and we are now telling them of the rich heritage of the medical profession. We would like to believe that this campaign has helped convince the public that our private medical care system is worth keeping as the biggest bargain of their lives. The many comments we have received, both from the medical profession and from the public, convince us that it has helped.

It is still, however, a job for both of us, you as physicians, and we as manufacturers, to justify this concept to a public already conditioned to a paternal political concern with health matters and to convince them that a private enterprise medical system is not only effective, but, in the long run, less expensive.

Perhaps in our urge to grow medically tall we have distorted and attenuated our old public image. We need social and economic width if we are to avoid "welfare state" control.

Millions now living and millions yet unborn will have healthier and happier lives because of the medical job we can do. Let's make sure their concept, our image, is an equally healthy one.

Penicillin Substitute

A drug meant to fight typhoid fever is playing an important role in the treatment of venereal disease, according to scientists at The University of Michigan Medical Center. "Synnematin B," the antibiotic can be used safely by patients who are allergic to penicillin. A report on its effectiveness was given by Albert H. Wheeler (Ph.D.) of the U-M Medical School, at the 11th annual U. S. Public Health Service Symposium on Advances in the Study of Venereal Diseases.

"Penicillin is at present the only reliable agent for the cure of syphilis," said Dr. Wheeler. "So when penicillin-sensitive patients contract the disease, the problem of treatment becomes very serious."

Synnematin B is just as effective as penicillin in checking syphilis in its early stages. Original tests with animals proved its safety and effectiveness. The drug has since been used on two patients, and did not cause even a mild allergic reaction.

Synnematin B was originally isolated by scientists at the Michigan Department of Health Laboratories about 10 years ago, and showed great promise in the treatment of typhoid fever and related diseases.

Clinicopathological Conference

Wayne State University College of Medicine

The patient, a fifty-seven-year-old Negro man, was first transferred to Detroit Receiving Hospital because of confusion. Transfer diagnoses included emphysema and cor pulmonale. Alcoholism was mentioned and pertinent data revealed blood pressure 170/115, pulse 100 and cardiomegaly. He was discharged improved to the Medical Clinic on vitamins, digitalis, and low salt diet.

Final admission occurred three months later, with symptoms of weakness, anorexia, fifty-pound weight loss and vague chest discomfort. The blood pressure was 110/90, extraocular movements were normal, pupils reactive, discs pale, and there was no evidence of A-V nicking or retinopathy. There was increased A-P diameter of the chest and the lungs were clear. The cardiac PMI was in the sixth interspace at the anterior axillary line, with distant heart tones, regular rhythm, A_2 lounder than P_2, and a grade 2 apical systolic murmur. The liver edge was 4 cm. below the right costal margin and no peripheral edema was evident. There was muscle wasting, but no fasciculations. The cranial nerves were intact, but there was loss of proprioception and vibratory sense below the knees. The deep tendon reflexes were hypoactive although left patellar and bilateral Achilles were not elicited.

Pertinent laboratory data included hemoglobin 12 gm., white blood count 4100, and negative urine. Bilirubin was 2.4 mg. per cent, alkaline phosphatase 7.6 Bodansky units, and thymol turbidity 4 units. The BUN was 54 mg. per cent and BSP 28 per cent. The blood sugar, serum sodium, potassium, chloride were normal, but CO_2 was 19.7 mEq./L. Prothrombin time was 19.8 seconds, with control of 12.0 seconds. Albumin was 3.0 and globulin 2.9 gm. per cent. The Kline test was positive. Liver biopsy revealed normal liver tissue and chest x-ray revealed cardiomegaly. Barium enema was negative and G I series revealed duodenal deformity. ECG revealed left ventricular hypertrophy.

The patient was redigitalized and given massive vitamins. Weakness, and cachexia marked his course, which was relentlessly downhill, and he expired 3 weeks after admission.

Dr. G. O. Clifford.—Since neurologic problems were prominent at least early in the course, would you comment, Dr. Bauer?

Dr. R. B. Bauer.—The diagnoses brought to mind are Korsakow's psychosis and Wernicke's encephalopathy, with or without beri-beri heart disease, and CNS lues. Nystagmus is not present to support the diagnosis of Wernicke's. This man had marked weight loss, etiology unknown, and general muscular wasting. One must, therefore, rule out motor neuron disease (progressive muscular atrophy, amyotrophic lateral sclerosis, or progressive bulbar palsy). If either of these had progressed to the point of causing death, fasciculations would have been observed. Does the patient have polyneuritis, as suggested by reflex and sensory changes? Alcoholic polyneuritis is usually characterized by painful, tender, sensitive feet with peripheral hypalgesia, not described here. Because of the posterior column disease (lack of position and vibratory sense), one thinks of pernicious anemia; however, he had no anemia, glossitis, gastric achylia is not mentioned, and there are no pyramidal tract signs. What about diabetes? Loss of vibration and position sense is frequently the early manifestation of peripheral neuritis associated with diabetes, but there was no evidence for diabetes. With marked weight loss and rapid deterioration, one must think of carcinoma. Carcinomatous neuropathy, especially in pulmonary and ovarian carcinoma, can present as a peripheral neuritis with muscle disease and frequently with cerebellar signs. There is degeneration of the dentate nucleus and it progresses to degeneration of the olive and involves the pyramidal tract. No mention is made of cerebellar involvement, and his neuropathy is not symmetrical. CNS lues has not been ruled out. It is mentioned that the optic disks were pale. The presence of posterior column involvement, absence of pain, sparing of the upper extremities, positive serology, and the loss of reflexes in the lower extremities is compatible with tabes dorsalis; however, I do not think

that neurological disease was the primary cause of death, but is rather an incidental finding.

Dr. Clifford.—You think, then, that alcoholism and polyneuritis are unlikely possibilities?

Dr. Bauer.—In a patient who is a chronic alcoholic, it is very likely that many of the symptoms were due to a peripheral neuritis associated with nutritional deficiency, but this is not the typical picture here and this is more compatible with "burned-out" tabes dorsalis.

Dr. Clifford.—Dr. Regan, this patient had extreme cardiomegaly, but the murmurs were not specific. What is your interpretation?

Dr. J. J. Regan.—The patient was first admitted here in a confused state and was found to have hypertension, which subsided. Physical examination revealed quiet heart sounds, a narrow pulse pressure, and the electrocardiogram indicated left ventricular hypertrophy. What are causes of left ventricular enlargement? Some obscure causes, such as collagen disease, sarcoid, amyloid, hemochromatosis, metastasizing or primary tumor, and parasitic infection, may be eliminated with absence of systemic changes. Severe chronic reduction of cardiac output may itself lead to marked weight loss. With questionable nutrition, the spector of beri-beri is raised. High output failure is unlikely with the narrow pulse pressure and absence of peripheral edema and plethora. Does the patient have pericardial effusion? He does have distant heart sounds and narrow pulse pressure, but there was no paradoxical pulse. Moreover, he had left ventricular hypertrophy and no pulmonary or right-sided congestion. The major cause of left ventricular hypertrophy is essential hypertension, but the blood pressure and fundi were normal. Aortic insufficiency is excluded for lack of characteristic murmur or pulse pressure. The narrow pulse pressure suggests aortic stenosis, but the absence of a characteristic murmur makes it doubtful. Occasionally with aortic stenosis one finds little or no murmur in the aortic area, but finds it limited to the mitral area, relatively high-pitched with mid-systolic accentuation. Does the patient suffer from cardiovascular lues because of its high correlation with central nervous system lues? Most cases of luetic aortitis are associated with some regurgitation of the aortic valve. Gumma of the myocardium does not produce left ventricular hypertrophy. A diffuse inflammatory process of the myocardium, associated with syphilis, is usually secondary to coronoary vascular involvement. Several clues to a diagnosis of idiopathic diffuse myocardial inflammation do exist: the long standing narrow pulse pressure, left ventricular hypertrophy, and diminished heart sounds. Etiologic considerations should include viral, immune, and deficiency mechanisms. This patient terminated in a sudden manner, which may be secondary to mural thrombi from the ventricles.

Dr. R. J. Bing.—One cannot exclude the possibility that this man did have a nutritional deficiency with beri-beri heart disease. The combination of neuropathy and cardiomegaly certainly suggests this. Dr. Regan, what criteria would you require for a diagnosis of beri-beri heart disease?

Dr. Regan.—Classically, one expects generalized cardiomegaly, resting tachycardia, a bounding pulse, widened pulse pressure, and a shortened circulation time. If studied, the cardiac output is increased even though signs of heart failure are present and the peripheral resistance and A-V oxygen difference are reduced. Also helpful in the acute stage would be determination of blood lactate and pyruvate levels; these are characteristically elevated as a reflection of the thiamine deficiency basic to the disorder, and the resulting inability to decarboxylate pyruvic acid which accumulates in the blood.

Dr. Clifford.—This patient was diagnosed as having emphysema and cor pulmonale, and possessed an increased A-P diameter of the chest. The CO_2 was somewhat depressed. Dr. Lewis, do you think he had some form of pulmonocardiac disease?

Dr. B. M. Lewis.—That he had cardiac disease is difficult to dispute, but that he had pulmonary disease, I have serious doubts. All we know is that the anterior posterior diameter of the chest was increased. It has been proven that a great many people in the sixth and seventh decade have increased anteroposterior diameter of the chest, but their pulmonary function is normal for their age group.

Dr. Clifford.—It seems the consensus that this patient suffered from nutritional deficiency and alcoholism. He may well have had polyneuritis, or possibly CNS lues. He seems to have had an idiopathic myocardial hypertrophy or myocarditis, possibly due to beri-beri heart disease. At this point, we'll turn the discussion over to the pathologists.

Dr. J. A. Brough.—At necropsy, the major gross pathologic changes were limited to the thoracic cavity. The heart weighed 600 grams. The left and right ventricular weights were 237 and 93 grams, respectively, indicating both left and right ventricular hypertrophy. There was dilatation of both ventricular chambers and extensive diffuse sclerosis of the left ventricular endocardium. There were many mural thrombi in various stages of organization. One of these on the septal surface of the left ventricular chamber reduced the capacity by 50 per cent (Fig. 1). There were no gross abnormalities of the valves and the coronary arteries were normal. The left and right lung weighed 500 and 900 grams, respectively. Numerous branches of the pulmonary arteries were occluded by thromboemboli. Major portions of the parenchyma of all lobes were replaced by multiple areas of infarction. The liver weighed 1000 grams and the spleen weighed 27 grams. Microscopically, diffuse hypertrophy of myocardial fibers was present. There was no element of perivascular or interstitial fibrosis nor inflammatory infiltration of any type. The most striking change was noted in the endocardium and subjacent myocardium, where there was diffuse collagenous thickening of the connective tissue. There was uniform encirclement of the trabeculae carnae and papillary muscles by this process. No elastic tissue could be demonstrated and the subendocardial myocardium exhibited marked vacuolar change. Other sections demonstrated mural thrombi in varying stages of organization. Mild diffuse vesicular emphysema and the formation of an occasional bulla was noted in the lung sections. The liver exhibited only centro-lobular congestion associated with a minimal fatty change of the parenchymal cells. The pathological findings are compatible with chronic beri-beri heart disease, with endocardial sclerosis, multiple mural thromboses, and resultant pulmonary infarction. In addition, there was an idiopathic remote necrosis of posterolateral columns of the mid-cervical spinal cord, mild diffuse vesicular emphysema, and an incidental small gastric leiomyoma.

Dr. Bing.—Do you find pathologic changes in acute beri-beri heart disease?

Dr. Brough.—In acute beri-beri, the heart is globular and massively dilated. Endocardial sclerosis and mural thrombosis are not present. Microscopically there is non-specific interstitial change and intracellular edema.

Dr. M. B. Levin.—Why do you use the term "beri-beri" rather than idiopathic heart disease?

Fig. 1.

Dr. Brough.—Beri-beri is used here in its classic connotation. This form of heart disease does not represent a deficiency of thiamine alone, but of multiple dietary factors. In some obscure cardiopathies termed beri-beri, patients did not respond to thiamine alone, but to a general well-balanced diet. In others, patients initially responded to thiamine, but later became refractory and presented this pathologic picture at necropsy. Still other cases were refractory to all forms of therapy.

Federal Legislation

The Keogh Bill (H.R. 10) allowing self-employed, professional men and others to make deductions in their income before taxes, in order to set up a retirement program, may be enacted this session of Congress. It has passed the House and is in the Senate. There is much pressure on the Senators to pass it and a few letters to our Michigan Senators will help. The Bill should be passed this year. An encouraging sign is that the Treasury Department has lessened its opposition to the measure if certain modifications are incorporated.

H.R. 10 is a step toward placing the self-employed and the professional and business groups on a very low step of the platform of benefits available to manufacturing and industry. We have been writing about this editorially for about twelve years, and are happy to see the progress now being made.

When and if this Bill passes, it will propose some new problems, how to activate it, what to do and how. We will be approached by various schemes and schemers with plans. The Florida State Medical Society has already set up a retirement program which many of its members are following—even without the benefit of tax free contributions.

At its meeting April 13, The Council of the Michigan State Medical Society considered this measure and instructed our Legal Counsel to provide information and suggestions. When this Bill passes, our membership will wish to take advantage of the best possible program for setting up a retirement fund. This action of The Council is a very forward step in that direction and we suggest that our members keep this in mind when the time comes.

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Health Insurance for Retirees

About all we have seen for the last several months have been items in the magazines and newspapers, in medical journals and bulletins, regarding health insurance for the senior citizen.

This agitation comes from several sources. It has been claimed that the 16 million people over sixty-five are in depleted financial straits and need help in their medical care. During their advanced years it is perfectly natural they will need more medical care.

This picture is definitely deceptive. Around twenty years ago when Blue Cross-Blue Shield started, provision was made for these older people. They were taken into pre-payment plans in groups without regard to age—just so they were an active member of that group. They were never cancelled out of the program because of age. That is almost a completely universal statement for all medically sponsored pre-payment programs. When a man left his employment through which he entered the pre-payment program, he was allowed

to continue at a slightly increased rate on direct payment. That was evidence not only of concern for the elderly citizens but of doing something for them.

Labor organizations and certain politicians and bureaucrats have for some years back been demanding more complete medical care under insurance at less cost, including complete care for the aged. This pressure and agitation have increased until it is now a wail of *"do something for the over 65's."*

We are now seeing and hearing more conferences on aging. Two were held in Lansing in April, one is scheduled for July in Ann Arbor and the President will hold one in Washington, D. C., next January. There are research programs going on at the University of Michigan, one in particular, stimulated by the Governor's Commission to Study Blue Cross, which has been under way for about three years and is about ready to make a report.

Pressure groups, labor groups and politicians are all demanding a solution. The medical profession has been studying this for years trying to find the best solution. Our volunteer programs have established special insurance programs for the retirees of meager income as well as those who can afford to carry regular insurance. The Forand type legislation is still very much in evidence. That bill itself probably will not pass, but could be sent through as a rider on other necessary legislation. The old Wagner-Murray-Dingell bills of thirty years ago were protested and condemned as socialized medicine. Most of their provisions have already been enacted in other measures. If a few more groups and services should be made a part of the government service, the only possible outcome would be through government operation and salaried doctors.

The medical profession must hold fast to what is left of private practice or be absorbed into the whole social security system. This is not the fight of a few doctors with vision, and with knowledge of what has gone in the past and with fear for the future.

This is everybody's fight.

This is *your* fight!!

Old Age Survivors and Dependent's Insurance

That is the official title of the Social Security Act. Another amendment has just been proposed to include the medical profession in social security coverage. Officially and persistently for many years, the American Medical Association has opposed having the medical profession included in this group, successfully so far.

We know there are many groups and many doctors who would welcome being included because of the retirement benefits and the fact that under present income laws it is difficult for self-employed persons to set up an adequate retirement program. Under social security, one is eligible to retire at sixty-five and is expected to do so. At that time, when he goes on retirement, depending on how long he has been covered, he can draw up to around $115 maximum and his wife half as much more, providing he does not earn more than $1,200 a year. At age seventy-two this restriction on earning is removed.

The medical profession, in general, does not retire at sixty-five but at seventy-four, on the average. Inclusion in the social security program would require that the M.D.'s pay into the program seven years of involuntary contributions before he is eligible to benefit from it. That fact is one of the reasons for non-participation of the medical profession, which as of now, is the only group not covered.

For approximately ten years, THE JOURNAL of the Michigan State Medical Society has advocated editorially that this restriction on social security benefits be removed. If that program is insurance, and its very name so proclaims it, why should any benefit which has been provided under the law, and which has been earned by contributions up to age sixty-five, be suspended or changed because a person earns more than $1,200 in a year or more than a stipulated amount within any one month.

We believe promised benefits should be available without restriction to whoever has qualified for them. We have suggested in the past, and we do so now, that an amendment be proposed to this social security act eliminating that restriction. We do not believe the government would lose money by carrying out the implied program of benefits. Most doctors would continue working and paying. The seven years of non-benefits have kept many of them out of the program so far. Other persons after age sixty-five would continue in the production economy.

We again propose this amendment to the social security act. Abolish the penalty for working. Pay honestly earned benefits.

Health Services

Michigan Medical Service has completed twenty years of operation, and one trend stands out. The number of services rendered per thousand subscribers

is constantly rising and has been from the very start. The amount paid for those services is also increasing.

About ten years ago Blue Cross and Blue Shield were concerned over these facts. They were considering whether this increase could be due to over-utilization. Harry F. Becker, M.D., of Battle Creek, was employed and spent several years visiting hospitals, studying records, trying to determine if there was over-utilization or justifiable increases. The number of entries into the hospitals and the number of services rendered by the doctors has constantly increased in proportion, as has the amount being paid. The hospital admissions from 1948 to 1957 show an average cost.

1948	$ 96.25
1949	110.84
1950	121.15
1951	137.30
1952	147.43
1953	155.93
1954	169.35
1955	179.29
1956	193.00
1957	213.92

This progress shows a trend. The same figures can be developed for Michigan Medical Service. The number of admissions during part of this period, determined as number of hospital days per thousand subscribers was:

1954	1005
1959	1237

In five years, there was an increase of 23 per cent in the more expensive hospital days per thousand subscribers. We have demonstrated a trend. We believe now that the medical profession and the hospital group organization—those rendering health services—should take a hint from labor who pointed the way several years ago. Mr. Reuther and his negotiators tied into their labor contracts a clause providing a certain definite higher wage for each specific increase in the cost of living as reported by the federal department effective every three months.

We suggest that Michigan Hospital Service and Michigan Medical Service establish an understanding with the state insurance commissioner to recognize the cost of living increase as automatically carrying with it a cost and increase of insurance premiums. Our auditors and economic advisors tell us that such an arrangement for the past several years in Michigan would have carried our two organizations through those years without the necessity of appealing to the commissioner frequently for increases, but doing it automatically.

Industry makes this change in wages each time the cost of living changes. They could do the same thing on withholding the premiums for Blue Cross and Blue Shield.

When Blue Cross and Blue Shield have gone to the State Insurance Commissioner requesting a rate increase, they have met delay running over months and the final allowance several percentages short of what was required.

The most prominent was late in 1956 when the Governor appointed a Commission to investigate the operation and procedures and to determine how more protection could be given for less money. Almost the entire year of 1957 was devoted to these inquiries with a tremendous amount of newspaper publicity. The final outcome was to authorize a study being conducted at the University of Michigan using about $328,000 donated by the W. K. Kellogg Foundation of Battle Creek. That study is still in process. Reports have been promised in the immediate future which should be a guide in future programs. The imminence of the report has not changed the increasing demand for more complete coverage and for protection of older citizens in spite of the very satisfactory programs built along the senior citizen line.

Some of the Michigan Medical Service Board, more than ten years ago, considered that special riders should be developed which when taken together would accomplish a complete medical coverage. Such an outline was studied and developed in planning, by which the demands of those wishing full coverage could have been met—thus negating their complaint so often heard that the only way full coverage could be obtained would be through compulsory health insurance by the government.

J. R. Seale, who studied medical care in both England and the United States, has made these conclusions:

1. The proportion of the gross national wealth of a nation devoted to medical care tends to remain constant.

2. It rises during national economic depressions and it falls during wars, because the proportion spent on medical care is constant, and in depressions the national income falls, while during wars it becomes artificially inflated.

3. A persistent rise in real per capita gross national income will tend to result in a gradual increase in the proportion spent on health.

(Digested from *JAMA*, December 12, 1959)

Michigan State Medical Society

The Ninety-Fifth Annual Session

H. J. Meier, M.D.
Coldwater
Council Chairman

Milton A. Darling, M.D.
Detroit
President

J. J. Lightbody, M.D.
Detroit
Speaker

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, September 25-26-27-28-29-30, 1960. The provisions of the Constitution and By-laws and the Official Program will govern the deliberations.

Milton A. Darling, M.D.
President

H. J. Meier, M.D.
Council Chairman

J. J. Lightbody, M.D.
Speaker

H. F. Falls, M.D.
Vice Speaker

Attest:
D. Bruce Wiley, M.D., *Secretary*

D. Bruce Wiley, M.D.
Utica
Secretary

H. F. Falls, M.D.
Ann Arbor
Vice Speaker

THREE-DAY SESSION OF HOUSE OF DELEGATES

September 25-26-27, 1960

First Meeting—Sunday, 8:00 p.m.

The 1960 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 25, at 8:00 p.m. The business of the House of Delegates will be transacted in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit.

The House will meet also on Monday, September 26 at 9:00 a.m. and 8:00 p.m., and on Tuesday, September 27, at 9:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

SEATING OF DELEGATES

"Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the Component County Society involved."—MSMS Bylaws, Chapter 9, Section 6.

Michigan State Medical Society

The Ninety-Fifth Annual Session

SHERATON-CADILLAC HOTEL, DETROIT

SEPTEMBER 25-26-27-28-29-30

INFORMATION

- **DETROIT WILL BE HOST TO MSMS IN SEPTEMBER, 1960.**

- **MSMS HOUSE OF DELEGATES** convenes Sunday, September 25, at 8:00 p.m., Grand Ballroom, Detroit. It will also hold two meetings on Monday, September 26 and two on Tuesday, September 27.

- **THE PROGRAM OF THE ASSEMBLY** for the 95th Annual Session of the Michigan State Medical Society lists guest speakers from all parts of the United States. They are the usual stars in the medical world who always grace the podium at annual conventions of the Michigan State Medical Society; they insure a valuable concentrated refresher course in all phases of medicine and surgery for the busy practitioners of Michigan, neighboring states, and the Province of Ontario.

- **DATES OF SCIENTIFIC ASSEMBLY:** Tuesday noon through Friday noon, September 27-30, 1960.

- **REGISTRATION,** Tuesday, 10:00 a.m. (September 27) through Friday noon (September 30), Fourth Floor, Sheraton-Cadillac Hotel. Present your State Medical Society, American Medical, or Canadian Medical Association membership card to expedite registration.

- **NO REGISTRATION FEE FOR STATE MEDICAL SOCIETY AND CMA MEMBERS.** Doctors of Medicine, who are not members of their state medical society or the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a $25.00 registration fee.

- **REGISTER AS SOON AS YOU ARRIVE. ADMISSION BY BADGE ONLY.**

- **MEMBERS OF MICHIGAN MEDICAL SERVICE** will meet in annual session, Tuesday, September 27, at 2:00 p.m. This meeting will follow the annual MMS luncheon which will be held in the English Room of the Sheraton-Cadillac Hotel.

- **ALL SUBJECTS** at the MSMS Annual Session are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

- **POSTGRADUATE CREDITS** given to every MSMS member who attends MSMS Annual Session.

- **SIX ASSEMBLIES**—16 Section Meetings—all on September 27-28-29-30.

- **SECTION MEETINGS** will follow the daily Assemblies, Tuesday, Wednesday, Thursday, Friday.

- **PAPERS WILL BEGIN AND END ON TIME.** The MSMS scientific meeting always features by-the-clock promptness and regularity.

- **TECHNICAL EXHIBITS** will contain much of interest and value. Two daily intermissions to view the exhibits have been arranged.

- **MILTON R. WEED, M.D., DETROIT,** is Chairman of the Committee on Arrangements for the 1960 Annual Session.

- **CABARET-STYLE DANCE AND ENTERTAINMENT,** with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom of the Sheraton-Cadillac Hotel on Thursday evening, September 29. All who register and their ladies are cordially invited to attend.

SCIENTIFIC ASSEMBLY

Tuesday-Wednesday-Thursday-Friday

September 27-28-29-30, 1960

SAVE AN ORDER FOR THE EXHIBITORS AT THE MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

Michigan State Medical Society

Ninety-Fifth Annual Session

HOUSE OF DELEGATES

SHERATON-CADILLAC HOTEL, DETROIT, SEPTEMBER 25-26-27, 1960

ORDER OF BUSINESS*

SUNDAY, SEPTEMBER 25, 1960

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

6:00 p.m.—Registration

8:00 p.m.—First Meeting

1. **Call to Order by Speaker**
2. **Report of Committee on Credentials**
3. **Roll Call**
4. **Appointment of Reference Committees**
   - (a) On Officers' Reports
   - (b) On Reports of The Council
   - (c) On Reports of Standing Committees
   - (d) On Reports of Special Committees
   - (e) On Constitution and Bylaws
   - (f) On Resolutions
   - (g) On Special Memberships
   - (h) On Rules and Order of Business
   - (i) On Legislation and Public Relations
   - (j) On Hygiene and Public Health
   - (k) On Medical Service and Prepayment Insurance
   - (l) On Miscellaneous Business
   - (m) On Executive Session
   - (n) On National Defense and Disaster Planning
5. **Speaker's Remarks—J. J. Lightbody, M.D., Detroit**
6. **President's Remarks—Milton A. Darling, M.D., Detroit**
7. **President-Elect's Remarks—K. H. Johnson, M.D., Lansing**
8. **Annual and Supplemental Reports of The Council —H. J. Meier, M.D., Coldwater, Chairman of The Council**
9. **Report of Delegates to American Medical Association—W. A. Hyland, M.D., Grand Rapids, Chairman**
10. **Brief of Annual Report of Woman's Auxiliary—Mrs. Harold H. Gay, Coleman**
11. **Brief of Annual Report of Michigan State Medical Assistants Society—Mrs. Reta V. Stahl, Albion**
12. **Report on Michigan Medical Service**

MONDAY, SEPTEMBER 26, 1960

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

9:00 a.m.—Second meeting

13. **Supplemental Report of Committee on Credentials**
14. **Roll Call**
15. **Awards:**
    - (a) Selection of Michigan's Foremost Family Physician
    - (b) Fifty-year Awards
16. **Resolutions†**
17. **Reports of Committees of the House of Delegates**
    - (A) Permanent Advisory Committee on Fees
    - (B) Committee on Committees
    - (C) Committee to Work With National Blue Shield
    - (D) Special Committee to Review Constitution and Bylaws
    - (E) Committee to Study Problem of Malpractice
    - (F) Committee to Study Michigan State Medical Society Publications
    - (G) Special Committee to Study Election of Councilors on Geographic Basis and the Status of Councilors as Voting Members of the House of Delegates
    - (H) Committee to Review the Financial Structure of MSMS
18. **Reports of**
    1. **MSMS Standing Committees**
       - (A) Committee on Postgraduate Medical Education
       - (B) Preventive Medicine Committee
         - (1) Committee on Rheumatic Fever Control
         - (2) Maternal Health Committee (and Subcommittees)
         - (3) Venereal Disease Control Committee
         - (4) Tuberculosis Control Committee
         - (5) Occupational Medicine Committee
         - (6) Mental Health Committee
         - (7) Child Welfare Committee (and Subcommittees)
         - (8) Iodized Salt Committee
         - (9) Geriatrics Committee
         - (10) Committee on Diabetes
       - (C) Public Relations Committee (and Subcommittees)
       - (D) Ethics Committee
       - (E) Legal Affairs Committee
    2. **MSMS Special Committees**
       - (A) Scientific Radio Committee
       - (B) Advisory Committee to Woman's Auxiliary
       - (C) Advisory Committee to Michigan State Medical Assistants Society

*See the Constitution, Articles IV, VII and XII, and the Bylaws, Chapter 9 on "House of Delegates."

†All resolutions, special reports, and new business shall be presented in writing in triplicate (Bylaws, Chapter 9, Section 10-m).

(D) Study Committee on Prevention of Highway Accidents
(E) Mediation Committee
(F) Special Committee to Meet With Michigan Funeral Directors Association

MONDAY, SEPTEMBER 26, 1960
Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

8:00 p.m.—Third Meeting

19. Supplemental Report of Committee on Credentials
20. Roll Call
21. Unfinished Business
22. New Business
23. Reports of Reference Committees
(a) On Officers' Reports
(b) On Reports of The Council
(c) On Reports of Standing Committees
(d) On Reports of Special Committees
(e) On Constitution and Bylaws
(f) On Resolutions
(g) On Special Memberships
(h) On Rules and Order of Business
(i) On Legislation and Public Relations
(j) On Hygiene and Public Health
(k) On Medical Service and Prepayment Insurance
(l) On Miscellaneous Business
(m) On Executive Session
(n) On National Defense and Disaster Planning

TUESDAY, SEPTEMBER 27, 1960
Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

9:00 a.m.—Fourth meeting

24. Supplemental Report of Committee on Credentials
25. Roll Call
26. Unfinished Business
27. New Business
28. Supplemental Reports of Reference Committees

TUESDAY, SEPTEMBER 27, 1960
English Room, Sheraton-Cadillac Hotel, Detroit

8:00 p.m.—Fifth meeting

29. Supplemental Report of Committee on Credentials
30. Roll Call
31. Unfinished Business
32. Supplemental Report of The Council
33. Supplemental Reports of Reference Committees
34. Elections
(a) Councilors:
2nd District—O. B. McGillicuddy, M.D., Lansing—Incumbent
3rd District—H. J. Meier, M.D., Coldwater—Incumbent
15th District—R. J. Mason, M.D., Birmingham—Incumbent
16th District—G. Thomas McKean, M.D., Detroit—Incumbent
(b) Delegates to American Medical Association
W. D. Barrett, M.D., Detroit—Incumbent
R. L. Novy, M.D., Detroit—Incumbent
G. W. Slagle, M.D., Battle Creek—Incumbent
(c) Alternate Delegates to American Medical Association
L. R. Leader, M.D., Detroit—Incumbent
Wm. Bromme, M.D., Detroit—Incumbent
J. R. Heidenreich, M.D., Daggett—Incumbent
(d) President-Elect
(e) Speaker of the House of Delegates
(f) Vice Speaker of the House of Delegates
35. Adjournment

ANNUAL SESSION APPOINTMENTS

Chairman of Arrangements
Milton R. Weed, M.D., Detroit

House of Delegates Press Committee
J. J. Lightbody, M.D., Detroit, Chairman
Milton A. Darling, M.D., Detroit
H. F. Falls, M.D., Ann Arbor
C. Allen Payne, M.D., Grand Rapids
Milton R. Weed, M.D., Detroit
D. Bruce Wiley, M.D., Utica

Scientific Press Committee
H. F. Dibble, M.D., Detroit, Chairman
A. B. Gwinn, M.D., Hastings
J. J. Lightbody, M.D., Detroit
A. E. Schiller, M.D., Detroit
Milton R. Weed, M.D., Detroit
C. L. Weston, M.D., Owosso

HOTEL RESERVATIONS
MICHIGAN STATE MEDICAL SOCIETY
95th Annual Session
Detroit, September 27-28-29-30, 1960

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to the Committee on Hotels for MSMS Convention, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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Committee on Hotels,
Michigan State Medical Society
c/o Sheraton-Cadillac Hotel
Detroit, Michigan

Please make hotel reservation(s) as indicated below:

———— Single Room(s) ———— persons

———— Double Room(s) for ———— persons

———— Twin-Bedded Room(s) for ———— persons

Arriving September ———— hour ———— A.M. ———— P.M.

Leaving ———— hour ———— A.M. ———— P.M.

Hotel of First Choice: ————————

Second Choice: ————————

Names and addresses of all applicants including persons making reservations:

Name	Address	City	State

Date ———— Signature ————————

Address ———————— City ————

MSMS HOUSE OF DELEGATES, 1960

Delegates and Alternates

(Names of Alternates appear in italics)

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J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
Speaker
H. F. Falls, M.D., 1313 E. Ann St., Ann Arbor
Vice Speaker
D. Bruce Wiley, M.D., 45310 Van Dyke, Utica
Secretary
G. B. Saltonstall, M.D., 112 Clinton St., Charlevoix
Immediate Past President
A. Verne Wenger, M.D., 132 Grand Ave., N.E., Grand Rapids
Honorary Member

ALLEGAN

Lewis F. Brown, M.D., 133 E. Allegan St., Otsego
James I. Clark, M.D., Box B, Fennville

ALPENA-ALCONA-PRESQUE ISLE

Elbert S. Parmenter, M.D., U.S. 23 South, Alpena
John W. Bunting, M.D., 110 N. First Ave., Alpena

BARRY

Alexander B. Gwinn, M.D., 102 E. State St., Hastings
Everett L. Phelps, M.D., 118 E. Walnut, Hastings

BAY-ARENAC-IOSCO

David A. Bowman, M.D., 101 W. John St., Bay City
Stanley A. Cosens, M.D., 101 W. John, Bay City
William G. Gamble, Jr., M.D., Mercy Hospital, Bay City
Edward R. Rodda, M.D., 101 W. John St., Bay City

BERRIEN

Noel J. Hershey, M.D., P.O. Box 222, Niles
Paul O. Rague, M.D., 960 Agard, Benton Harbor
F. Alan Kennedy, M.D., 239 Pipestone, Benton Harbor
Frederick H. Lindenfeld, M.D., 8 N. St. Joseph, Niles

BRANCH

Robert M. Leitch, M.D., 304 N. Broadway, Union City
Robert J. Fraser, M.D., 22 W. Pearl, Coldwater

CALHOUN

Harvey C. Hansen, M.D., 417 Post Bldg., Battle Creek
Geo. T. Kelleher, M.D., 235 North Ave., Battle Creek
Salvatore A. Yannitelli, M.D., 1331 W. Michigan Ave., Battle Creek
Keith S. Wemmer, M.D., 1472 W. Michigan Ave., Battle Creek

CASS

Sherman L. Loupee, M.D., 110 W. Division St., Dowagiac
Uriah M. Adams, M.D., Marcellus

CHIPPEWA-MACKINAC

Donald D. Finlayson, M.D., 301 E. Spruce St., Sault Ste. Marie
Earl S. Rhind, M.D., 300-306 Court St., Sault Ste. Marie

CLINTON

Franklin W. Smith, M.D., 105 S. Ottawa St., St. Johns
James M. Grost, M.D., 110 Oakland St., St. Johns

DELTA-SCHOOLCRAFT

James R. Dehlin, M.D., 8 South 11th St., Gladstone
James H. Fyvie, M.D., Manistique

DICKINSON-IRON

Donald R. Smith, M.D., 100 W. "A" St., Iron Mountain
Earl R. Addison, M.D., 412 Superior St., Crystal Falls

EATON

Byron P. Brown, M.D., 339 S. Cochran, Charlotte
Robert E. Landick, Jr., M.D., 111 S. Cochran, Charlotte

GENESEE

Clifford W. Colwell, M.D., 328 S. Saginaw St., Flint 3
J. Leonidas Leach, M.D., 3007 Industrial Ave., Flint
Lawrence G. Bateman, M.D., 1928 Lewis St., Flint 6
Frank D. Johnson, M.D., 653 S. Saginaw St., Flint 3
John E. Wentworth, M.D., 1651 Chevrolet Ave., Flint 4
William F. Buchanan, M.D., 238 W. Caroline St., Fenton
John Quin, Jr., M.D., 2765 Flushing Rd., Flint
Harvey V. Sparks, M.D., 2765 Flushing Rd., Flint
Ernest P. Griffin, Jr., M.D., 1505 Arrow Lane, Flint
David McTaggart, M.D., 312 Patterson Bldg., Flint
John M. Schwartz, M.D., 4300 S. Saginaw, Flint
Thomas N. Eickhorst, M.D., 1604 Mott Foundation Bldg., Flint

GOGEBIC

Wayne A. Gingrich, M.D., Ironwood
Florian J. Santini, M.D., Ironwood

GRAND TRAVERSE-LEELANAU-BENZIE

Frank H. Power, M.D., 116 Cass St., Traverse City
Charles E. Lemen, M.D., 110 S. Madison, Traverse City

GRATIOT-ISABELLA-CLARE

John M. Wood, M.D., 314 S. Brown, Mt. Pleasant
Franklin E. McCoy, M.D., Central Michigan Community Hospital, Mt. Pleasant

HILLSDALE

Arthur W. Strom, M.D., 32 S. Broad St., Hillsdale
Luther W. Day, M.D., Grosvener Bank Bldg., Jonesville

HOUGHTON-BARAGA-KEWEENAW

Paul S. Sloan, M.D., 214 Clark St., Houghton
Leonard C. Aldrich, M.D., 1609 E. Houghton Ave., Houghton

HURON

Charles W. Oakes, Jr., M.D., Harbor Beach
Clare A. Scheurer, M.D., Pigeon

INGHAM

Franklin L. Troost, M.D., 4378 W. Delhi, Holt
John M. Wellman, M.D., 301 Seymour St., Lansing
Herbert W. Harris, M.D., 609 N. Washington, Lansing
Lawrence A. Drolett, M.D., 3526 W. Saginaw St., Lansing 17
Robert M. Stow, M.D., 512 Michigan National Tower, Lansing
Forest M. Dunn, M.D., 301 Seymour St., Lansing
Howard C. Comstock, M.D., 1031 E. Michigan Ave., Lansing
Richard W. Pomeroy, M.D., 609 N. Washington, Lansing
Philip F. Lange, M.D., 1923 S. Cedar St., Lansing
Samuel H. Rutledge, Jr., M.D., 110 W. Hillsdale St., Lansing

IONIA-MONTCALM

Robert E. Rice, M.D., P.O. Box 271, Greenville
Richard E. Campbell, M.D., 106 N. Depot St., Ionia

JACKSON
Ross V. Taylor, M.D., 517 Wildwood, Jackson
John W. Rice, M.D., 421 McNeal St., Jackson
Charles R. Lenz, Jr., M.D., 405 First St., Jackson
Jack P. Bentley, M.D., 404 McNeal St., Jackson

KALAMAZOO
W. Kaye Locklin, M.D., 136 E. Michigan, Kalamazoo
Don Marshall, M.D., 252 E. Lovell St., Kalamazoo
Frederick C. Ryan, M.D., Borgess Medical Center, Kalamazoo
Donald G. May, M.D., 516 Whites Rd., Kalamazoo
Robert R. Dew, M.D., 1711 Merrill St., Kalamazoo
Robert E. DeLong, M.D., Borgess Medical Center, Kalamazoo
Robert B. Burrell, M.D., 1711 Merrill St., Kalamazoo
Karel R. Slatmyer, Jr., M.D., 103 N. Burdick, Kalamazoo

KENT
W. Clarence Beets, M.D., 124 Fulton St. E., Grand Rapids 2
J. Russell Brink, M.D., 50 College Ave. S.E., Grand Rapids
Allison R. Vanden Berg, M.D., 26 Sheldon Ave. S.E., Grand Rapids
Frederick C. Brace, M.D., 1498 Lake Dr. S.E., Grand Rapids
Wm. J. Fuller, M.D., 833 Lake Drive S.E., Grand Rapids
James A. Ferguson, M.D., 72 Sheldon Ave. S.E., Grand Rapids
J. Duane Miller, M.D., 50 College Ave. S.E., Grand Rapids
Felix S. Alfenito, Jr., M.D., 26 Sheldon Ave. S.E., Grand Rapids
Frederick S. Gillett, M.D., 50 College Ave. S.E., Grand Rapids
Noyes L. Avery, Jr., M.D., 833 Lake Dr. S.E., Grand Rapids
Richard A. Rasmussen, M.D., 1810 Wealthy St. S.E., Grand Rapids
Dale L. Kessler, M.D., 1840 Wealthy St. S.E., Grand Rapids
William C. Baum, M.D., 26 Sheldon Ave. S.E., Grand Rapids
Douglas P. Moore, M.D., 110 Fulton St. E., Grand Rapids
Victor A. Notier, M.D., 50 College Ave. S.E., Grand Rapids
Christopher H. Southwick, M.D., 55 Sheldon Ave., Grand Rapids

LAPEER
Harry B. Zemmer, M.D., 311 Clay St., Lapeer
Wm. C. Heitsch, M.D., 307 Clay St., Lapeer

LENAWEE
George C. Wilson, M.D., Box 224, Clinton
Frances W. Balice, M.D., 128 E. Butler, Adrian

LIVINGSTON
Harold C. Hill, M.D., 116 N. Michigan, Howell
Edwin S. Woodworth, M.D., 1200 Byron Rd., Howell

LUCE
Wm. R. Purmort, Jr., M.D., Newberry State Hospital, Newberry
Lawrence E. Grennan, M.D., 210 W. John St., Newberry

MACOMB
Edward G. Siegfried, M.D., 91 Cass, Mt. Clemens
Daniel L. Rousseau, M.D., 67 Cass, Mt. Clemens
James H. Jewell, M.D., 18215 Utica Rd., Roseville
Edmund J. Dudzinski, M.D., 51034 Washington, New Baltimore

MANISTEE
Robert R. Garneau, M.D., Mercy Community Hospital, Manistee
Ernest B. Miller, 324 First St., Manistee

MARQUETTE-ALGER
Eugene R. Elzinga, M.D., 514 E. Hewitt St., Marquette
Frederick C. Sabin, M.D., 101 S. Front St., Marquette

MASON
Herbert G. Bacon, Jr., M.D., 101 N. Main, Scottville
William F. Sutter, M.D., 220 S. James, Ludington

MECOSTA-OSCEOLA-LAKE
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Edward W. Van Auken, M.D., 229 S. Warren, Big Rapids

MENOMINEE
John R. Heidenreich, M.D., Daggett
Herman R. Brukardt, M.D., 534 First Street, Menominee

MIDLAND
Harold L. Gordon, M.D., The Dow Chemical Co., Midland
Martin J. Ittner, M.D., 217 N. Saginaw Rd., Midland

MONROE
Samuel N. Kelso, Jr., M.D., 753 No. Monroe St., Monroe
Reginald A. Frary, M.D., 423 E. Elm Ave., Monroe

MUSKEGON
H. Clay Tellman, M.D., Medical Arts Center, Muskegon
DeVere R. Boyd, M.D., 1735 Peck St., Muskegon
Norbert W. Scholle, M.D., 2500 Peck St., Muskegon Heights
Wm. H. Tyler, M.D., 1435 Peck St., Muskegon

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Robert E. Paxton, M.D., Fremont

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Louis F. Hayes, M.D., Gaylord
Charles L. Oppy, M.D., Roscommon

NORTHERN MICHIGAN
Gerald A. Drake, M.D., 511 Waukazoo St., Petoskey
Leonard W. Reus, M.D., 226 Park Ave., Petoskey

OAKLAND
Felix J. Kemp, M.D., 880 Woodward Ave., Pontiac
Harold A. Furlong, M.D., 940 Riker Bldg., Pontiac
Chauncey G. Burke, M.D., 1022 Riker Bldg., Pontiac
Walter J. Zimmerman, M.D., 258 Washington Sq. Bldg., Royal Oak
Merle A. Haanes, M.D., 704 Pontiac State Bank Bldg., Pontiac
Arthur R. Young, M.D., 906 Riker Bldg., Pontiac
Michael C. Kozonis, M.D., 1301 Pontiac State Bank Bldg., Pontiac
Robert M. Bookmyer, M.D., 1890 Southfield Rd., Birmingham
F. Michael Sheridan, M.D., 1307 S. Washington, Royal Oak
Rockwood W. Bullard, Jr., M.D., 5790 M-15, Clarkston
Thomas D. Grekin, M.D., 603 W. Eleven Mile Rd., Royal Oak
Vincent P. Russell, M.D., 324 Washington Sq. Bldg., Royal Oak

Elmer J. Mueller, M.D., 1775 E. Fourteen Mile Rd., Birmingham
Norman F. Gehringer, M.D., 880 Woodward Ave., Pontiac
Paul T. Lahti, M.D., 3600 West Thirteen Mile Rd., Royal Oak
James R. Quinn, M.D., 505 Pontiac State Bank Bldg., Pontiac

OCEANA

Willis A. Hasty, M.D., Shelby, Mich.

ONTONAGON

Wm. F. Strong, M.D., Ontonagon
Harold B. Houge, M.D., Ontonagon

OTTAWA

John H. Kitchel, M.D., 414 Franklin St., Grand Haven
Gerrit J. Kemme, M.D., R.R. No. 3, Zeeland

SAGINAW

Joseph P. Markey, M.D., 808 N. Michigan, Saginaw
A. Carl Stander, M.D., 1411 Court St., Saginaw
Vernon V. Bass, M.D., 826 N. Michigan, Saginaw
Donald V. Sargent, M.D., 1703 N. Michigan, Saginaw
Hugh T. Caumartin, M.D., 1537 N. Washington, Saginaw
Robert F. Powers, M.D., 529 W. Genesee St., Saginaw

ST. CLAIR

John J. Coury, M.D., 1209 Tenth St., Port Huron
John A. Serniac, 104 So. Main, Yale

ST. JOSEPH

S. Albert Fiegel, M.D., 111 S. Monroe, Sturgis
Roscoe J. Fortner, M.D., 137 Portage Ave., Three Rivers

SANILAC

Keate T. McGunegle, M.D., Sandusky
Michael H. Jayson, M.D., Marlette

SHIAWASSEE

Claude L. Weston, M.D., Matthews Bldg., Owosso
Norman F. Bach, M.D., 113 E. Williams St., Owosso

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Lloyd L. Savage, M.D., 147 W. Lincoln, Caro
Edward N. Elmendorf, II, M.D., Vassar

VAN BUREN

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Adelbert L. Stagg, M.D., Hartford

WASHTENAW

Harold F. Falls, M.D., University of Michigan Hospital, Ann Arbor
Henry A. Scovill, M.D., 107 Washtenaw, Ann Arbor
Victor M. Zerbi, M.D., 27 S. Prospect, Ypsilanti
Otto K. Engelke, M.D., Washtenaw County Health Department, Ann Arbor
Theodore G. Kabza, M.D., St. Joseph Mercy Hospital, Ann Arbor
R. Wallace Teed, M.D., 215 A S. Main St., Ann Arbor
Norman L. Banghart, M.D., 1950 Manchester Rd., Ann Arbor
Clarence E. Crook, M.D., 2112 Wallingford, Ann Arbor
Walter W. Hammond, Jr., M.D., 905 W. Ann Arbor Trail, Plymouth
Scott T. Harris, M.D., 27 So. Prospect, Ypsilanti
John W. Smillie, M.D., 2615 Overridge Drive, Ann Arbor
Harry A. Towsley, M.D., University Hospital, Ann Arbor

WAYNE

David I. Sugar, M.D., 13120 Broadstreet, Detroit 38
Don W. McLean, M.D., 10 Peterboro, Detroit 1
Homer A. Howes, M.D., 650 Bedford Lane, Grosse Pte. Park
Clarence I. Owen, M.D., 1544 Vinewood Ave., Detroit 16
James J. Lightbody, M.D., 1553 Woodward Ave., Detroit 26
Milton R. Weed, M.D., 1997 E. Grand Blvd., Detroit 11
Robert L. Novy, M.D., 858 Fisher Bldg., Detroit 2
James B. Blodgett, M.D., 76 W. Adams St., Detroit 26
William S. Carpenter, M.D., 18255 W. McNichols Rd., Detroit 19
Francis P. Rhoades, M.D., 5057 Woodward Ave., Detroit 2
Ralph R. Cooper, M.D., 850 Lakeland, Grosse Pointe 30
Donald N. Sweeny, Jr., M.D., 8445 E. Jefferson, Detroit 14
Albert D. Ruedemann, M.D., 1553 Woodward Ave., Detroit 26
Sidney Adler, M.D., 3011 W. Grand Blvd., Detroit 2
Eugene A. Osius, M.D., 1553 Woodward Ave., Detroit 26
Raphael Altman, M.D., 5057 Woodward Ave., Detroit 2
James D. Fryfogle, M.D., CD & Medical Concourse, Northland Center, Detroit 35
Perry C. Gittins, M.D., 20210 Renfrew Ave., Detroit 21
Edward J. Tallant, M.D., 14001 Greenfield, Detroit 27
Jack Rom, M.D., 8600 W. McNichols Rd., Detroit 21
Duncan A. Cameron, M.D., 2021 Monroe, Dearborn
Joseph G. Molner, M.D., 334 Bates St., Detroit 26
Luther R. Leader, M.D., 1553 Woodward, Detroit 26
Gaylord S. Bates, M.D., 861 Monroe Blvd., Dearborn
Wyman C. C. Cole, Sr., M.D., 1077 Fisher Bldg., Detroit 2
George T. Bradley, M.D., 1553 Woodward Ave., Detroit 26
Edgar E. Martmer, M.D., 693 Washington Rd., Grosse Pointe 30
A. Hazen Price, M.D., 62 West Kirby, Detroit 2
George S. Fisher, M.D., 1709 David Whitney Bldg., Detroit 26
Alfred M. Large, M.D., 1553 Woodward Ave., Detroit 26
Meyer O. Cantor, M.D., 4850 Charing Cross Rd., Birmingham
Richard E. Wunsch, M.D., 497 Rivard Blvd., Grosse Pointe 30
William J. Yott, M.D., 854 Lakeshore Rd., Grosse Pte. Shores
Floyd B. Levagood, M.D., 14056 Artesian, Detroit 23
Joseph A. Witter, M.D., 344 Glendale Ave., Highland Park 3
Elden C. Baumgarten, M.D., 8045 E. Jefferson Ave., Detroit 14
Hugh W. Henderson, M.D., 17830 E. Warren, Detroit 24
Joseph Hickey, M.D., 6004 W. Fort St., Detroit 9
Louis J. Bailey, M.D., Northland Center, Southfield
Jacob F. Wenzel, M.D., 18555 E. Warren, Detroit 36
Charles W. Sellers, M.D., 18545 Schoolcraft Ave., Detroit 23
Edwin H. Fenton, M.D., 15125 Grand River Ave., Detroit 27
William M. Tuttle, M.D., 1553 Woodward Ave., Detroit 26
John R. Brown, M.D., 702 Maccabees Bldg., Detroit 2
George J. Moriarty, M.D., 3011 W. Grand Blvd., Detroit 2
Alvin E. Price, M.D., 1553 Woodward Ave., Detroit 26
Herbert W. Devine, M.D., 22101 Moross Rd., Detroit 36

John G. Slevin, M.D., 10 Witherell St., Detroit 26
Robert G. Swanson, M.D., 936 Alter Rd., Detroit 15
Ralph A. Johnson, M.D., 7815 E. Jefferson Ave., Detroit 14
A. Zack Rogers, M.D., 20451 Mack Ave., Grosse Pte. Woods
Clarence L. Candler, M.D., 20040 Mack Ave., Detroit 36
Max L. Lichter, M.D., 2900 Oakwood Blvd., Melvindale
William L. Brosius, M.D., 16150 Sorrento, Detroit 35
Edwin F. Dittmer, M.D., 18412 Mack Ave., Grosse Pte. Farms
Robert K. Whiteley, M.D., 216 Lakeland Ave., Detroit 30
Arthur B. Levant, M.D., 15715 E. Warren, Detroit 24
Edward M. Vardon, M.D., 12897 Woodward Ave., Highland Park 3
James C. Danforth, Jr., M.D., 20175 Mack Ave., Grosse Pte. Park
Joseph R. Montante, M.D., 18715 Bretton Dr., Detroit 23
Brock E. Brush, M.D., 2799 W. Grand Blvd., Detroit 2
Edward H. Lauppe, M.D., 1551 Woodward Ave., Detroit 26
Howard C. Rees, M.D., 15700 Mack Ave., Detroit 24
Frank S. Perkin, M.D., 3011 W. Grand Blvd., Detroit 2
William L. Sherman, M.D., 10 Peterboro St., Detroit
Laurence F. Segar, M.D., 10 Witherell St., Detroit 26
John W. Derr, M.D., 702 Maccabees Bldg., Detroit 2
Harold B. Fenech, M.D., 324 Professional Bldg., Detroit 1
Melvin S. Dennis, M.D., 751 S. Military St., Dearborn
Raymond J. Kokowicz, M.D., 19440 Van Dyke, Detroit 34
Roger V. Walker, M.D., 1553 Woodward Ave., Detroit 26
Elmer B. Miller, M.D., 20 Oxford Rd., Pleasant Ridge
Rosser L. Mainwaring, M.D., 1910 Russell, Dearborn
Carl J. Sprunk, M.D., 2900 Oakwood Blvd., Melvindale
Hugh M. Fuller, M.D., 1257 David Whitney Bldg., Detroit
Louis E. Heideman, M.D., 20211 Greenfield Rd., Detroit 35
A. Jackson Day, M.D., 245 Cleverly Rd., Grosse Pointe Farms
Russell T. Costello, M.D., 3001 W. Grand Blvd., Detroit 2
Alexander Blain, III, M.D., 2201 E. Jefferson, Detroit 7
Lyle W. Korum, M.D., 18585 E. Warren St., Detroit 36
Frank P. Walsh, M.D., 654 Fisher Bldg., Detroit 2
Clarke M. McColl, M.D., 2799 W. Grand Blvd., Detroit 2
Sidney E. Chapin, M.D., 125 N. Military, Dearborn 7
E. Clarkson Long, M.D., 13995 Rutland Ave., Detroit 27
Eugene J. Steinberger, M.D., 6402 W. Fort St., Detroit 9
William B. McIntyre, M.D., 1145 David Whitney Bldg., Detroit 26
John G. Graham, Jr., M.D., 491 Lincoln Rd., Grosse Pointe 30
Herbert E. Pedersen, M.D., 381 Golfcrest Dr., Dearborn
Philip J. Huber, M.D., 1724 Bassett, Royal Oak
John W. Sigler, M.D., 1356 Greenlawn Blvd., Birmingham
Frederick B. Steiner, M.D., 7675 Ridge Rd., Plymouth
Walter L. Anderson, M.D., 1553 Woodward, Detroit 26
Francis L. Granger, M.D., 14160 Gratiot Ave., Detroit 5
Alexander B. Stearns, M.D., 1116 Maccabees Bldg., Detroit 2
Harry E. Bagley, M.D., 7541 Oakman Blvd., Dearborn
Dwight C. Ensign, M.D., Franklin
John P. Ottaway, M.D., 18226 Mack Ave., Grosse Pointe Farms
Lewis Green, M.D., 13000 Grand River, Detroit 27
Edgar G. Cochrane, M.D., 503 Medical Arts Bldg., Detroit 3
Everal M. Wakeman, M.D., 22276 Garrison Ave., Dearborn
Robert P. Lytle, M.D., 10 Peterboro St., Detroit
Lambertus E. Beeuwkes, M.D., 13014 Mackenzie Ave., Detroit 28
Maurice M. Silverman, M.D., 17301 W. Eight Mile Rd., Detroit 35
Thomas M. Batchelor, M.D., 18060 Conant, Detroit 34

WEXFORD-MISSAUKEE
Gregory P. Moore, M.D., 734 East Division St., Cadillac

Annual Coller-Pemberthy Medical Conference

Traverse City, Michigan—Park Place Hotel

Thursday and Friday, July 28, 29, 1960

E. L. Thirlby, M.D., and Frederick A. Coller, M.D., *Honorary Chairmen;* Frank H. Power, M.D., *Presiding.*

THURSDAY, JULY 28, 1960

10:00 A.M., Park Place Hotel

Harry Towsley, M.D., Ann Arbor, Michigan—Laboratory Procedures in Office Practice
Marion S. DeWeese, M.D., Ann Arbor, Michigan—Lesions of Renal Arteries
George Morley, M.D., Ann Arbor, Michigan—Once a Cesarian, Always a Cesarian
Richard M. McKean, M.D., Detroit, Michigan—Thyroid Dysfunction
J. Dewey Bisgard, M.D., Omaha, Nebraska—Emergency Primary Gastric Resection for Acute Perforation
Arthur Curtis, M.D., Ann Arbor, Michigan—Common and Benign Lesions of the Skin.

Lunch—Park Place Hotel

2:00 P.M.

Richard Bing, M.D., Detroit, Michigan—Certain Aspects of Congestive Failure
Philip D. Wilson, M.D., New York, N. Y.—Osteoporosis, Modern Concept of Diagnosis and Management
Albert C. Furstenberg, M.D., Ann Arbor, Michigan—Deafness
Edwin Ellison, M.D., Milwaukee, Wisconsin—Current Thoughts on Pancreatitis
Carl E. Badgley, M.D., Ann Arbor, Michigan—Some Unusual Tendon Injuries
Robert M. Zollinger, M.D., Columbus, Ohio—Treatment of Duodenal Ulcer

6:30 P.M.—Cocktail Party—Park Place Hotel

7:00 P.M.—Dinner—Park Place Hotel

Frederick A. Coller, M.D., *Presiding*
Guests: Dr. Alexander Ruthven, Dr. Harlan Hatcher, Dr. Henry F. Vaughn, Dr. William Hubbard

FRIDAY, JULY 29, 1960

Clinic and Case Demonstrations, James Decker, Munson Hospital
9:30 A.M.—Short Symposium on Trauma
Merle M. Musselman, M.D., Omaha, Nebraska—A Critical Evaluation of Shock and Its Management
Clifford Benson, M.D., Detroit, Michigan—Abdominal Trauma in Infants
Reed Nesbit, M.D., Ann Arbor, Michigan—Traumatic Urinary Tract
Edgar Kahn, M.D., Ann Arbor, Michigan—Spinal Cord Injuries
Case Demonstrations by Staff of Munson Hospital
Discussion and Questions by Audience and Guests
1:00—Lunch—James Decker, Munson Hospital

The Eye Bank at Ann Arbor

John W. Smillie, M.D.
St. Joseph Mercy Hospital,
Ann Arbor, Michigan

Two years ago the first eye bank in the state of Michigan was established here at the University of Michigan Medical Center with the sponsorship of the Michigan Lions Club. The official name of the eye bank is the "Michigan Eye Collection Center."

Corneal grafting has been done here at the University Medical Center, the Ann Arbor Veterans Administration Hospital, and St. Joseph Mercy Hospital for about the last five years.

When the cornea becomes cloudy or irregular, the light rays are prevented from reaching the retina or are so distorted that a clear image is not formed.

For some period of time we can continue to give patients sight with corneal contact lenses after they can no longer be made to see with corrective glasses. When the contact lenses fail it is necessary to do a corneal graft or corneal transplant. An instrument, called a trephine, is used to remove the graft from a donor eye and then the diseased tissue from the recipient cornea is removed. The healthy tissue from the donor eye is then put in place and sutured into position.

This sounds like a relatively simple procedure, and yet for years was unsuccessful. Prior to 1900 the corneal grafting was unsuccessful because animal corneas were used for grafting and these did not work.

Since 1900 human material has been used, the antibiotics have arrived, the instruments and suture material have been improved, and we have the steroids to cut down inflammatory response. Thus, corneal grafting is now more successful. It is still a most hazardous procedure, successful results being obtained perhaps in half the cases. Nonetheless, when a patient has poor vision in each eye, and he knows that the vision may be cleared by operation, he will often say "Doc, what have I got to lose?"

Donor eyes must be removed within a two-hour period after death and should be used within a forty-eight hour period thereafter. We usually try to use the donor eye as soon as possible after the removal; not often after twenty-four hours. To date the most successful method of preservation is by refrigeration.

Prior to having the eye bank here we simply waited until donor eyes were received and then called the patient in. This is the method we still use of choice, but sometimes an eye will rupture and the procedure must be done at once. In this case an eye is flown in from one of the many other collection centers throughout the country.

The eyes that are willed to the Michigan Eye Collection Center are used for research purposes if they are not used for corneal surgery. At present we are accepting donations of eyes only within the immediate geographic area of Ann Arbor.

Almost anyone can donate his eyes, including patients who use glasses and patients who have had a cataract operation. As long as a cornea is clear it makes little difference what the age of the person is. Sex, color or creed makes no difference, for all religions have approved of the procedure. The enucleation of the eyes does not mar the appearance of the body.

The eyes cannot be designated for a specific person. They are used for the next patient on the eye surgeon's list. If the eyes are not used within forty-eight hours, they are trans-shipped to the National Eye Bank in New York by air to allow for redistribution.

If we cannot use the eyes for grafting they are carefully studied in research to help find causes and cures for blindness.

There is no charge for the eyes and the eye bank furnishes the eyes free to patients in hospitals needing them. They are never bought or sold.

If you wish to donate your eyes at death you may write the Michigan Eye Collection Center at the University Medical Center, Ann Arbor, or the office in St. Joseph Hospital and forms will be sent to you for your signature to indicate that you wish to have this done.

The Michigan state laws are such that you cannot actually will the eyes yourself. Permission to remove eyes must be given by the legal next of kin, say husband or wife. Nonetheless, if you have signed a form indicating that you wish to will yours eyes, the next of kin usually grants this permission.

Prepared at the request of the editors of the monthly news letter of Saint Andrew's Episcopal Church, Ann Arbor, and entitled by them "At Death . . . a Gift of Sight?"

Doctor Smillie is an active staff member, Saint Joseph Mercy Hospital, Chief of Eye Service, Ann Arbor Veterans Administration Hospital, and Assistant Professor of Ophthalmology, University of Michigan.

Population of Physicians Increased in Nation in '59

The physician population of the United States increased by 4,769 in 1959, a gain of 660 over the 1958 gain.

The 1959 increase results from the licensing of 8,269 new doctors of medicine, minus the deaths of approximately 3,500 doctors, according to the 1959 report of the American Medical Association Council on Medical Education. There was no marked decrease evident in any state, according to the Council.

The Council reports that of the 8,269 new physicians to be licensed, 1,626 were foreign-trained. The report also points out that the number of failures among applicants for licensure by written examination decreased from 15.8 per cent in 1958 to 12.9 per cent in 1959.

Project HOPE to Aid People of Asia

The People-to-People Health Foundation, a private, non-profit corporation, is in the midst of its newest project, "Health Opportunities for People Everywhere" which spells out H-O-P-E.

Project HOPE, undertaken by the Advertising Council as a public service campaign, seeks to raise funds for a "floating medical center." The center is a fully-equipped hospital ship made available by the U. S. Navy and renamed HOPE by the Foundation. The ship will visit Southeastern Asia where the hospital beds of the ship will be used primarily to provide an opportunity for medical teaching rather than in attempting to meet the overwhelming problem of caring for the vast mass of sick people in Asiatic lands.

It is estimated that a fund of $3,500,000 will be needed to operate the ship and its educational program for a year. The campaign headquarters is Box 9808, Washington 15, D. C.

Urges Patients Follow Drug Advice of Their Physicians

The nation's drug industry has warned patients taking prescription drugs to rely solely on the advice of their own physicians for the determination of proper drugs for their illnesses.

Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association, said he is "alarmed by reports that patients are ignoring and questioning prescriptions of the one and only person qualified to advise them—their own doctor."

Dr. Smith declared, "In the past two decades the pharmaceutical industry has brought hundreds of new compounds from its laboratories to save lives and physicians have worked overtime to perfect their knowledge of these products—what they will and will not accomplish, and how they may help the unique condition of each individual patient. Much of this vital information comes properly to doctors

through their own technical channels of communication and as a result of studies and symposia conducted by learned specialists. For this there is no safe substitute."

Ease MD Shortage

The W. K. Kellogg Foundation, Battle Creek, has given a $1-million-dollar grant to the University of New Mexico to establish a school of basic medical sciences. The AMA will cooperate in the proposal. Students will attend the basic medical sciences school for two years and then transfer to traditional four-year medical schools for their junior and senior years.

Rural Health Meeting Hears Plea for Aged

A New York doctor told the 15th National Conference on Rural Health at Grand Rapids that society has been illogical and inconsistent in its attitude toward compulsory retirement and a more realistic approach is necessary.

Theodore G. Klumpp, M.D., a member of the American Medical Association's Committee on Aging, said, "The same care exercised in selecting a person for employment should be used in retiring that individual."

"Certainly a man isn't fit one day and unfit the next because one page on the calendar has turned."

Doctor Klumpp pointed out that an entirely new set of social, economic, and political needs are being created as by-products of the technological advances of medical science.

* * *

DOCTORS OF MEDICINE, dentists, youth leaders, farm group representatives, and others participated in the 15th National Conference on Rural Health at Grand Rapids.

Sponsored by the American Medical Association's Council on Rural Health, the three-day meeting explored the challenging health problems of rural America.

Fred A. Humphrey, M.D., Fort Collins, Colorado, rural health council chairman, explained that through the work of many groups, communities previously without physicians have obtained them, health insurance programs for rural groups have been set up, and the general health of rural communities has improved.

Sessions were devoted to "careers in the field of medicine," the needs of aging and such nutritional topics as foods, additives, and faddism.

* * *

THE CONFERENCE ALSO heard an address by Dena C. Cedarquist, head of the department of foods and nutrition, College of Home Economics, Michigan State University on the problems of determining the adequacy of Americans' diets.

She said figures on the tonnage consumption of certain foods were available and in isolated cases homemakers can provide records of what is eaten in their households. But actually, she said, we know little about the food intakes of individuals and should be skeptical of such statements as "one-half of the population is undernourished with respect to calcium intake."

Appeals to Students

The University of Chicago's School of Medicine recently conducted 200 high school students on a seven-hour tour of its facilities. At the conclusion of the tour Dean Lowell Coggeshall urged the students to study medicine "even if you are short of funds."

Dean Coggeshall declared, "Every place you go there is a demand for more doctors from the public, industry and homes for the aged."

"We can point now to doctor shortages in several areas of medicine—anesthesiology, pathology and radiology among them," added Dr. Ward Darley, executive director of the Association of American Medical Colleges.

Encourage Paramedical Careers

The Women's Auxiliary to the Medical Society of Milwaukee County is currently sponsoring Paramedical Careers Clubs for more than 250 students in local high schools.

The doctors' wives began this program seven years ago by encouraging interested teenagers to form Future Nurse Clubs. The "paramedical" title was adopt-

Honor Doctor Carr

The first Earl I. Carr, M.D., Award was given at the AMA National Conference on Rural Health at Grand Rapids to the Roseville Health Council. The award will recognize the community health organization in Michigan for its outstanding health programs throughout the past year.

The award, established by the Michigan Health Council, honors Doctor Carr, who has been one of its most active members, founder and president of the Michigan Foundation for Medical and Health Education, recipient of many citations for distinguished service, and a medical practitioner for half a century. Doctor Carr has practiced surgery in Lansing for years.

ed last year to attract students who did not want to enter nursing but showed interest in other careers in the health field.

Northwestern Alters Medical School Courses

A revolutionary new medical school curriculum that will cut the student's course of study from eight to six years has been announced by Northwestern University.

In addition to revising the curriculum and reducing the length of time required for a medical degree, Northwestern will admit especially talented students directly into the medical school from high school.

A pilot study of the program will begin in the fall of 1961 with 25 talented students, Dr. Richard H. Young, dean of the Medical school said.

Both Johns Hopkins and Stanford University medical schools have been developing similar programs, he adds.

BMA Aids MD Visitors

The Council of the British Medical Association has established an International Medical Advisory Bureau to provide a personal advisory service for medical practitioners visiting the United Kingdom. The Bureau is located at British Medical Association House, Tavistock Square, London, W.C.I.

Overseas medical visitors are cordially invited to visit the Bureau as soon as possible after arrival for information about postgraduate education facilities and visits to hospitals and clinics, or assistance about suitable accommodations, or general information on cars, sports, traveling, exhibitions, theatres, etc.

Associate Editor Appointed

The World Medical Association has appointed J. Gosset, M.D., editor of *Concours Medical* of Paris, to be associate editor of *World Medical Journal*. Stanley S. B. Gilder, M.D., formerly editor of the *Journal of the Canadian Medical Association*, is the executive editor of *World Medical Journal*.

Says Zeal Is Gone

Social workers have lost their passion for social justice, Robert H. MacRae, executive director of the Metropolitan Chicago Welfare Council, declared at the University of Michigan. Mr. MacRae delivered the Jane Addams Memorial Lecture to the recent eighth annual Social Work Progress Institute.

One of the costs of professionalizing social work, MacRae said, was the loss of the passion displayed by Miss Addams, American social worker who founded Chicago's Hull House. Today, it is not social workers, but economists and labor leaders, who stir the public conscience, he said.

Conversion Provisions Now Mandatory in N. Y.

The insurance industry, doctors and others have followed with interest the new New York legislation which will require convertibility provisions in health insurance.

New York will become the first state in the nation requiring that all group health insurance plans allow conversion to individual policies for any persons leaving a group.

Two bills making this conversion privilege mandatory were passed by the State legislature during the closing days of the session, upon strong urging of Gov. Nelson Rockefeller.

The measures provide that insurance companies and Blue Cross-Blue Shield must make available—and employers and unions must buy—the conversion privilege as part of any group contact. All persons covered by the group for three months are eligible for the option. There is no restriction as to age or pre-existing conditions not excluded under the group contract.

Surgical, and in-hospital medical and room-and-board expenses are to be insured. In the case of indemnity plans, three levels are offered at prevailing state-approved rates. Surgical schedules will run from $250 to $300.

For persons aged sixty and over who have been in a group for two years, the premium shall not exceed a ceiling approved by the State insurance department.

Chinese Materials

Pergamon Press, an international scientific publishing house with head offices in New York and London, now maintains bureaus in Paris, Frankfort, Milon, Los Angeles and Washington, D. C. Pergamon Press, which acts as publishers for many scientific societies and organizations throughout the world, has, at the National Library of Medicine, added recent acquisitions of Chinese language material which seem to fall into five general categories: photolithographs of ancient medical classics; herbals and collections of prescriptions and formulae for medicinal herb preparations still in common use; works, both ancient and modern, on acupuncture and moxibustion; popular handbooks and guides to basic health rules and practices in hygiene, and monographs on Western medical and pharmaceutical practice.

MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Recommended Follow-up Procedure For Premarital Serologic Tests

The diagnosis of syphilis is not based solely upon the results of laboratory tests. It is a decision of the physician, based upon history, physical examination and the aid of laboratory tests. It is his decision to determine whether or not the patient has a biologic false positive or is actually infected with syphilis. Although the RPCF test is usually considered to be more specific than many of the standard reagin tests for syphilis (such as Kahn, Kline, Kolmer), nevertheless, it does not necessarily mean that all persons with a reactive Kahn and non-reactive RPCF are biologic false positives. (For example, in treated syphilis, the RPCF is quite likely to become non-reactive before the Kahn test.) However, if the RPCF is reactive, one can be quite certain in most instances that it is not a biologic false positive. In very early syphilis, the Kahn and other reagin tests will become reactive before the treponemal tests such as the RPCF or Treponema Pallidum Immobilization (TPI). If a person were in this early stage of the disease, it could well be possible to miss the infection if one depended entirely on the treponemal test.

Following is the recommended follow-up procedure:

1. If either the Kahn test or the Reiter Protein Complement Fixation (RPCF) test is reactive, the tests should be repeated after a reasonable interval of time—ten days to two weeks.

2. If the second tests are both non-reactive, no special dispensation for marriage is required; a regular medical certificate (Form V-90) can be issued. The RPCF test in this instance would be performed only upon special request by the physician, since it is routinely done on reactive Kahn tests only.

3. If the *Kahn test is reactive* and the RPCF test is non-reactive (after the serology has been repeated), a special dispensation may or may not be required, depending upon the decision of the physician. He may issue the regular medical certificate if he is convinced that the patient is not infected with syphilis nor has been previously treated for syphilis. His decision should be based upon (a) adequate history either for syphilis or treatment for same, or lack of such history; (b) physical examination; and (c) laboratory aids. If the patient has a history of syphilis or treatment for same, a special dispensation is required.

4. If the *Kahn test is reactive* and the *RPCF test is reactive*, a special medical dispensation for marriage license is required. It will be issued by the Michigan Department of Health under certain circumstances such as adequate treatment, diagnosis of congenital syphilis (proven), or demonstrated pregnancy, if patient is currently under therapy. Application blanks for special dispensation for marriage (Form V-94) are available on request from the Division of Tuberculosis and Adult Health, Michigan Department of Health, Lansing 4, Michigan.

5. If the *Kahn test is non-reactive* and the *RPCF test is reactive*, a special dispensation is required and may be issued under the condition listed in item 4.

Live Birth or Fetal Death

To die without having been born would seem to be a paradox. Yet, in Michigan each year, there are a number of death certificates filed for infants who lived a few minutes or hours but for whom no birth record was ever made. Thus, according to the record, they died although they were never born. This kind of thing can and does seriously disturb statisticians.

This is the census year. All birth and death certificates will be carefully matched. These vital statistics will be used in numerous ways by many people. It is our hope, therefore, that the records will be as accurate as it is humanly possible to make them.

Statistics on the state level can only be as accurate as those produced locally. Since the physician is responsible for completion of birth and death certificates, he is the source of all state vital statistics. And there is aparently still some confusion regarding these certificates as they apply to fetal and neonatal deaths.

A fetal death, or stillbirth, is death prior to the complete expulsion from its mother of a product of conception which has advanced through the 20th week of uterogestation. The death is evidenced by the fact that after expulsion the fetus does not breathe or show any sign of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Under these conditions, a stillbirth certificate must be filed.

If, however, the child shows any signs of life after expulsion, even though it be momentary, and regardless of the length of uterogestation, the birth shall be registered as a live birth and a death certificate shall also be filed. Birth is considered complete when the child is altogether outside the body of the mother, even if the cord is uncut and the placenta still attached.

Information on birth and death certificates is of great value in perinatal mortality studies. Physicians and record librarians of hospitals can do a great service if they will make sure that the proper type of certificate is filed for each fetal and neonatal death.

To Represent MHC On Aging Commission

Harry B. Zemmer, M.D., of Lapeer, president emeritus of the Michigan Health Council, was selected by the Council last month to membership on the new Michigan Commission on Aging.

Long active in scientific and administrative medical activities, Dr. Zemmer brings to the Commission an outstanding record of public service. He served for many years on the State's Mental Health Commission, both as member and Chairman. He also has held numerous county and state medical society offices, including an eight year term as MSMS Councilor from the 7th District.

H. B. Zemmer, M.D.

The Commission on Aging, to which Dr. Zemmer was named, was established by the Legislature in 1960 and begins operations July 1, 1960. It supplanted the Governor's appointive Commission on Aging and a Legislative Advisory Council on Problems of the Aging. As originally proposed, it was to be made up of five governmental ex-officio and six citizen members. At the request of the MSMS however, the measure was amended to add a "representative of the Michigan Health Council," making the membership twelve.

In an organizational meeting held in the Governor's office on May 27, the Commission elected James E. Brophy, Detroit, Chairman, John B. Martin, Grand Rapids, Vice-Chairman, and Charles Odel, Detroit, Secretary.

The Commission sponsored a series of regional meetings during the spring and will conduct the Michigan Conference on Aging in Lansing in September. Recommendations from the state-wide conference will go to the White House Conference on Aging in January at Washington, D. C.

Eleven 50-year Grads Honored by Wayne University

College of Medicine alumni of Wayne State University held their ninety-second reunion and clinic day May 4 at the Hotel Fort Shelby.

More than 250 graduates attended both the scientific sessions and dinner-dance, according to Chairman Rosser L. Mainwaring, M.D.

The science program began at 9:30 a.m. with presentations in surgery, medicine, obstetrics and gynecology, psychiatry and pediatrics.

At the banquet, nine fifty-year graduates of the College of Medicine were given Golden Anniversary Certificates by Irving W. Sander, M.D. They are: Harry J. Butler, M.D., Highland Park; Ulysses Durocher, M.D., Windsor; Henri L. Gratton, M.D., Detroit; William E. Miller, M.D., Detroit; Fred Organ, M.D., Detroit; Alvord R. Sanderson, M.D., Grosse Pointe; Elisha S. Sevensma, M.D., Grand Rapids; Rene J. St. Louis, M.D., Detroit; George H. Southwick, M.D., Grand Rapids. Unable to attend were Edward G. Dimond, M.D., Flint, and Louis J. Sebille, M.D., Pontiac.

Scientific papers were given by Drs. Herbert Robb, C. Gordon Campbill, Prescott Jordan, Lawrence Berman, Benjamin W. Drompp, Jacques S. Gottlieb, Gerald S. Wilson, Frederico A. Arcari, Charles S. Stevenson, M. S. Meyer, Charles Whitten, Osborne A. Brines, Charles G. Johnston, Benjamin Lewis, Kam Moghissi, James M. Pierce, Jr., and Alfred Large.

Clarence I. Owen, M.D., Detroit, is president of the alumni group.

Scholarship awards were made to Robert A. Abramovitz, '62, sophomore, for the highest attainments in the first two years, and to Ronald S. Seltzer, '60, for highest scholarship for the four years.

Honorary Membership in the Wayne State University Medical Alumni was given to Milton A. Darling, M.D., in appreciation of many achievements including service as president of the Michigan State Medical Society.

Muir Clapper, M.D., of Wayne faculty, was given a Distinguished Service Award for devotion to the teaching of the medical student.

Social Security Asks Prompt Medical Reports

The Social Security Administration at Lansing has made a plea that doctors act promptly when they have medical report forms to complete for social security disability benefits.

"When you get one of these forms, it is your patient who is seeking your assistance. This is not just another government form. This is a plea for help from your patient," the administration points out.

The appeal continues:

"A patient faced with a lengthy illness, loss of income, possibly with a family dependent on him, has a serious mental, as well as physical, burden. If he can establish that he is disabled for any substantial gainful work, there may be monthly cash benefits for him and his family. Frequently, even if no cash benefits are immediately payable, the amount of his future benefits can be protected.

"When one of your patients files an application for social security disability benefits, or applies to protect his future benefits rights, he is asked to furnish medical evidence showing the nature and extent of his disability. The responsibility for providing this rests with him, just as he must prove his age, for example. Since almost no patient can be his own physician, the disabled individual must ask his doctor to help him. With the help of members of the medical profession, the Social Security Administration has devised some forms on which this information can be conveniently supplied. The Social Security Administration furnishes these forms to its claimants, but the doctor may make his report in whatever form he sees fit, so long as it covers the essential facts—that is, the history of the disabling condition, as the doctor knows it, the symptomatology, clinical findings, and diagnosis.

"If the medical reports are slow in coming in, or incomplete, the patient's claim is delayed or even denied, since the law provides that he must have a disability which is 'medically determinable.' "

Detroit Surgical Society Reports New Officers

The Detroit Surgical Society held its annual election in April and reports the following officers: Paul J. Connolly, M.D., president; Donald N. Sweeny, Jr., M.D., president-elect; Edward M. Vardon, M.D., secretary; Henry J. Vandenberg, Jr., M.D., treasurer, and J. W. Deer, M.D., audit control officer. Members of the Council are John Reid Brown, M.D., Raphael Altman, M.D., Philip J. Huber, M.D., Joseph A. Witter, M.D., Homer Smathers, M.D., and James J. Horvath, M.D.

Detroit Surgeon to Head Michigan Academy

C. R. Lam, M.D.

Conrad R. Lam, M.D., Detroit, is the new president of the Michigan Academy of Science, Arts and Letters. Doctor Lam, chief thoracic surgeon at Henry Ford Hospital, was chosen at the annual meeting held March 26 at Ann Arbor. The 65th annual meeting of the Michigan Academy will be held next March at Wayne State University. Other officers include C. P. Loomis, East Lansing, vice-president; F. C. Bald, Ann Arbor, secretary; V. H. Jones, Ann Arbor, treasurer, and S. W. Baker, Jr., Ann Arbor, editor.

U-M Aging Conclave Soon

"Aging in the 'Sixties—Decade for Action" will be the theme of the University of Michigan's 13th annual Conference on Aging, June 27-29.

More than 300 are expected to attend the conference, designed to study ways of carrying out recommendations which will emerge from the 1961 White House Conference on Aging.

Participants will discuss channels of action and also how recommendations may be carried out within specialized fields of interest—health, housing, income, employment, education, free time, institutional administration, and social services.

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HEART BEATS

(This material is provided by the Michigan Heart Association)

New Officers Installed

Ben I. Johnstone, M.D., Detroit, is the new president of the Michigan Heart Association. He took office at the spring meeting of the Board of Trustees in March when Alfred T. Wilson, Grosse Pointe, vice-president of the National Bank of Detroit, was elected chairman of the board. Dr. Johnstone succeeds Donald S. Smith, M.D., Pontiac, and Mr. Wilson succeeds Frank N. Isbey, Detroit. John D. Littig, M.D., Kalamazoo, was named president-elect, Sidney E. Chapin, M.D., Dearborn, secretary, and Walter C. Folley, Detroit, treasurer. Association vice presidents are Mrs. Ruth McEvoy, Muir Clapper, M.D., and Douglas Donald, M.D., all from Detroit; Moses Cooperstock, M.D., Marquette; Milton Shaw, M.D., Lansing, and James C. Zeder, Bloomfield Hills.

B. I. JOHNSTONE, M.D

New board members elected at the annual meeting in February were Harold W. H. Burrows, Birmingham; Roy K. Erickson, Grosse Pointe; J. L. Gillie, Flint; J. King Harness, Detroit; James M. Smith, Detroit; H. Gordon Wood, Grosse Pointe; Richard McCaughey, M.D., Detroit; Richard A. Rasmussen, M.D., Grand Rapids; and Ross V. Taylor, M.D., Jackson. Re-elected members are: Muir Clapper, M.D., Detroit; F. D. Dodrill, M.D., Bloomfield Hills; H. M. Golden, M.D., Flint; Robert Hoving, Jackson; Mrs. Herbert Milliken, Flint; Jack Pickering, Detroit, and Donald S. Smith, M.D., Pontiac.

SRO at "Heart Day" Scientific Session

The first annual "Michigan Heart Day" brought more than a thousand persons to the Statler-Hilton Hotel in Detroit. All of the sessions were well attended but the Scientific Session proved to be a "Standing Room Only" event. Drs. Samuel A. Levine, Boston (Coronary Artery Disease), Thomas M. Durant, Philadelphia (Congestive Heart Failure), and John Stirling Meyer, Detroit (Cerebral Occlusive Disease), addressed an over-capacity audience of more than 600 physicians in the Wayne Ballroom.

Other events in the day-long program were a public forum, at which Louis N. Katz, M.D., Chicago, and Ancel Keys, Ph.D., and Mrs. Keys, Minneapolis, spoke to more than 500 persons; a session for heart unit delegates; a business luncheon and a dinner dance.

Grants for Heart Research

The Michigan Heart Association Research Committee recommendations were approved by the Board of Trustees and a sum of $330,275 has been allocated for the three categories of the Research Program in the following amounts:

Dean's Fund	$ 60,000.00
Medical Student Fellowships	15,000.00
Grants-in-Aid	255,275.00

Grants-in-Aid have been awarded to the following responsible investigators:

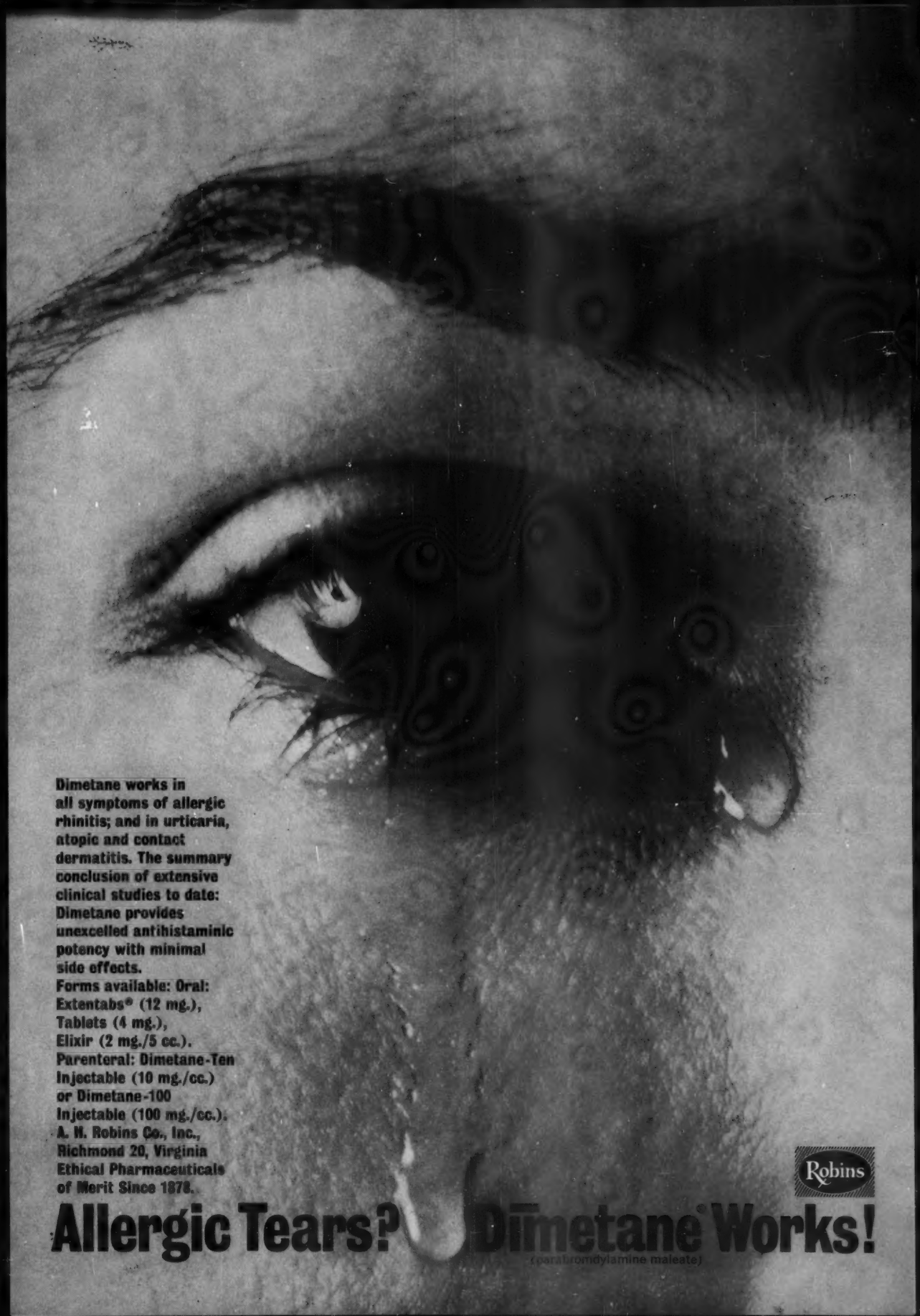
Marion I. Barnhart, Ph.D., Wayne State University, Cellular Sites for Synthesis of Proteins Important in Blood Coagulation.

Lloyd M. Barr, Ph.D., University of Michigan, Electrical and Mechanical Activity and Responsiveness of Arterial Smooth Muscle from Normotensive and Hypertensive Animals.

Bernard Bercu, M.D., Wayne County General Hospital, "The Measurement of Myocardial Blood Flow With Radio-

(Turn to Page 958)

"National Heart Research Day" observation in Michigan featured an Awards Luncheon honoring two of the Medical Student Research Fellows of the Michigan Heart Association. F. D. Dodrill, M.D., MHA Past President and Chairman of the Association's Research Committee, is shown with Drake Duane *(left)* and Condon R. Vander Ark *(right)*. Mr. Vander Ark, a junior Medical Student at the University of Michigan, received the Distinguished Achievement Award, and Mr. Duane, a sophomore Medical Student at Wayne State University, received the Meritorious Achievement Award.



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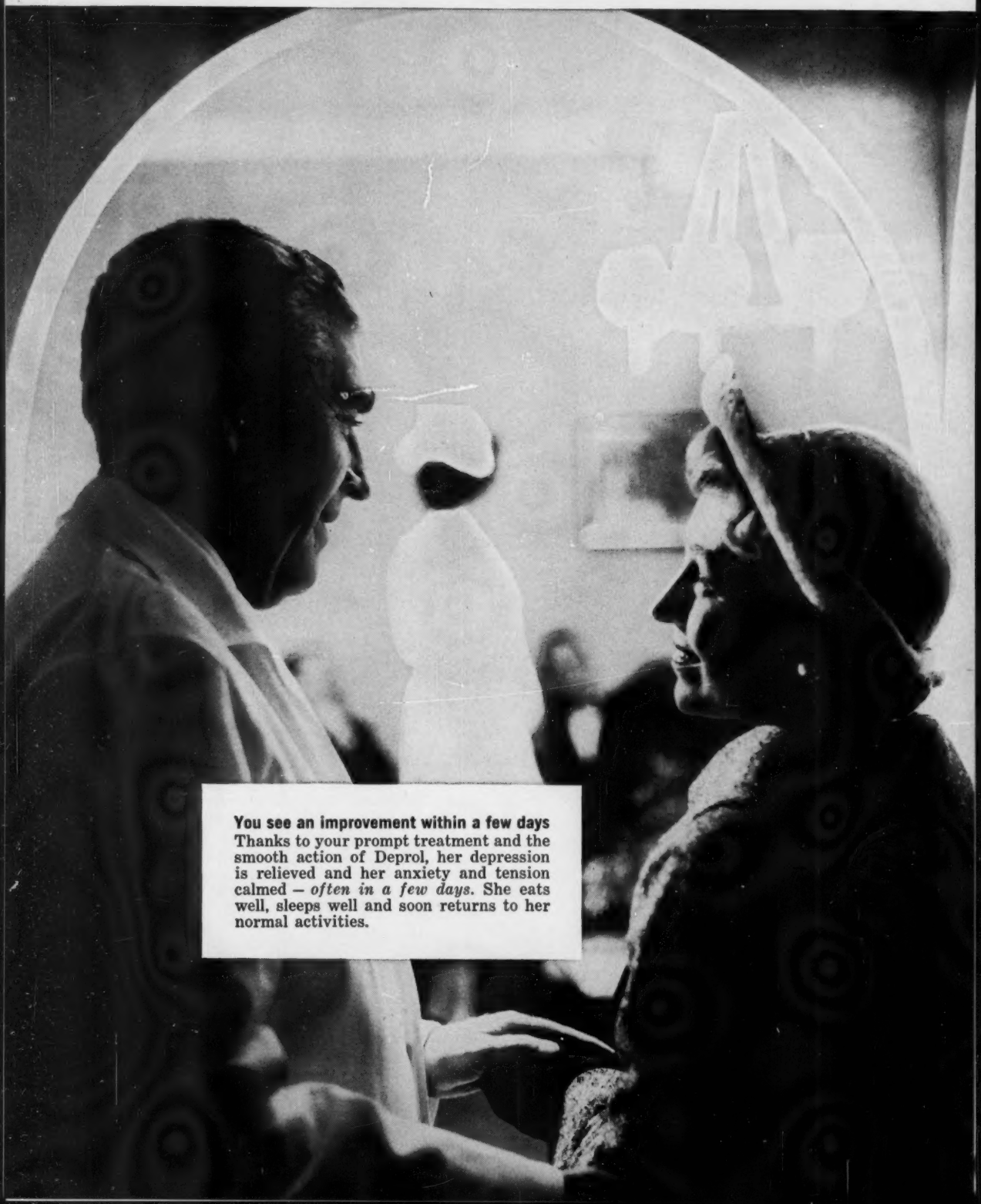

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation–*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

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Grants for Heart Research

(Continued from Page 954)

active Sodium" and "A Comparison of Myocardial Blood Flow in the Fibrillating Heart During Cardiac Massage and During Retrograde Perfusion of the Aorta.

Richard Bing, M.D., Wayne State University, Cardiac Metabolism and the Study of Glycolytic Pathways in the Anoxic Heart; Myocardial Metabolism of Fatty Acids.

Pedro Blaquier, M.D., University of Michigan, Renin and Angiotensinase in Various Stages of Experimental Hypertension in the Rat.

James B. Blodgett, M.D., Grace Hospital, Studies of Entrance to the Heart and Great Vessels, Including Open Cardiotomy by Means of Infusion of Arterial Blood into the Proximal Aorta, Occlusion of the Descending Aorta, Cardiac Inflow Occlusion and Cardioplegia.

Herbert Sloan, M.D., University of Michigan, Evaluation of Cardiac Function Following Heart Lung Bypass.

D. Emerick Szilagyi, M.D., Henry Ford Hospital, An Investigation of the Use of Vascular Substitutes in the Replacement of Arterial Segments.

D. G. Vernall, Ph.D., University of Michigan, The Teratogenic Effects of Trypan Blue on the Cardiovascular System of Mice.

John M. Weller, M.D., University of Michigan, Investigation of Abnormalities of Sodium and Potassium Metabolism in Hypertension.

Park Willis, III, M.D., University Hospital, Investigation of the Mechanism of Blood Coagulation with Special Reference to Problems of Thromboembolic Diseases.

Robert F. Ziegler, M.D., Henry Ford Hospital, Continuation of the Measurement and Determination of the Significance of the Areas Inscribed under the Various Electrocardiographic Deflections, Particularly in Multiple Unipolar Precordial Leads, Principally for the Better Detection of Increased Cardiac Chamber Work and Size.

Andrew J. Zweifler, M.D., University Hospital, The Effect of Heparin on Experimental Thrombosis in Dogs.

A. J. Boyle, M.D., Wayne State University, Plasma Colloid Stability in Normal and Atherosclerotic Subjects.

George O. Clifford, M.D., Wayne State University, Mechanism of the Coagulation Abnormalties Induced by Hyperlipemia and Its Modification by Certain Agents.

F. D. Dodrill, M.D., Harper Hospital, Mechanical-Heart Lung Project: Heart Valve Implantation.

Sibley Hoobler, M.D., University of Michigan, Arteriosclerosis and Hypertension.

Thomas N. James, M.D., Henry Ford Hospital, Morphologic Studies of the Human Heart with Clinical Correlation.

Joseph S. Jasper, Ph.D., Wayne State University, A Study of Serum Surface Tension in Atherosclerosis.

Shirley A. Johnson, Ph.D., Henry Ford Hospital, The Effect of the Administration of Oral Anticoagulants and of Heparin on the Blood Coagulation Mechanisms.

Prescott Jordan, M.D., Wayne State University, Aortic Valvular Replacement.

Jan J. Kabara, Ph.D., University of Detroit, Simultaneous Use of Tritium and Carbon-14 Metabolities to Study the Dynamics of Lipid Metabolism.

Sidney D. Kobernick, M.D., Sinai Hospital, The Pathogenesis of the Effect of Exercise on Experimental Cholesterol Atherosclerosis.

Conrad R. Lam, M.D., Henry Ford Hospital, Experimental Cardiovascular Surgery.

Benjamin M. Lewis, M.D., Wayne State University, Pulmonary Capillary Bed in Cardio-Respiratory Disease.

Perry Martineau, M.D., Herman Kiefer Hospital, Blood Viscosity in Relation to Coronary Atherosclerosis.

John Stirling Meyer, M.D., Wayne State University, Pathogenesis and Treatment of Hypertensive Encephalopathy. A Study of Experimental Production of Hypertensive Encephalopathy and the Response to Treatment.

Nicholas J. Mizeres, M.D., Wayne State University, The Neural Effect on the Coronary Circulation.

Yoshikazu Morita, M.D., Wayne State University, 1. Metabolism in Renal Disease (a) Protein metabolism in acute renal failure, (b) Mechanism of acid excretion in chronic renal disease. 2. The Use of Citrate in Regional Anticoagulation During Hemodialysis.

E. E. Muirhead, M.D., Woman's Hospital, The Influence of Renal Cells Grown in Tissue Culture on Experimental Hypertension.

Jan Nyboer, M.D., Harper Hospital, Evaluation of Ultra-Low Frequency Ballistocardiography and Electrical Impedance Plethysmography.

Robert C. Reynolds, University of Michigan, A Study of the Effects of pH and Ionization on the Actions of the Sympathomimetic Amines in the Mammalian Heart.

Herbert J. Robb, M.D., Wayne State University, Study of Microscopic Vascular Dynamics in Various Forms of Shock and Study of Vascular Changes Which Occur with Administration of Drugs Which Change the Caliber of Vessels and Affect Their Blood Flow.

Paul A. Rondell, Ph.D., University of Michigan, Factors Influencing the Electrolyte Composition of Vascular Smooth Muscle.

David Sandweiss, M.D., Sinai Hospital, Survey of 200 Patients with Ulcer in Relation to Coronary Heart Disease.

Walter H. Seegers, Ph.D., Wayne State University, Blood Coagulation: Purification of Inhibitors and Mechanisms of Their Action.

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Pathology Comment

The Biopsy That Let Us Down

How does it happen that even with a biopsy specimen the pathologic changes are sometimes missed? We are indebted in part to the Texas Society of Pathologists for the following reminders that may make the difference between a successful biopsy and a "near miss":

1. Has it been secured from the right site? Wrong areas frequently are biopsied in the nasopharynx, bronchus, or urinary bladder.

2. Is the amount of tissue adequate? Just because we examine the specimen under the microscope, the whole specimen doesn't have to be microscopic in size! Samples should include normal and abnormal tissue . . . don't be skimpy!

3. Improper handling of the specimen is another frequent cause of error. Do not dry it on a piece of gauze. Place it in a fixative promptly. Avoid pinching with clamps.

4. Consult the pathologist about diagnostic problems prior to biopsy. Plans may then be made for bacteriological studies or imprints on such tissues as lymph nodes, where the etiological agent might otherwise be missed. Such procedures must be planned in advance and executed prior to fixation of the tissue.

5. If there is any doubt about the significance of the written report, discuss it with the pathologist. Positive vaginal cytology reports should be confirmed with histological study of tissue from the cervix or endometrium prior to treatment.

6. And don't forget, the more information you can give your pathologist, the better he can evaluate the specimen. Has the patient had previous operations? It is important for the pathologist to be able to review the previous slides.

(This article is provided by the Michigan Pathological Society.)

Conference on Kidney at U-M

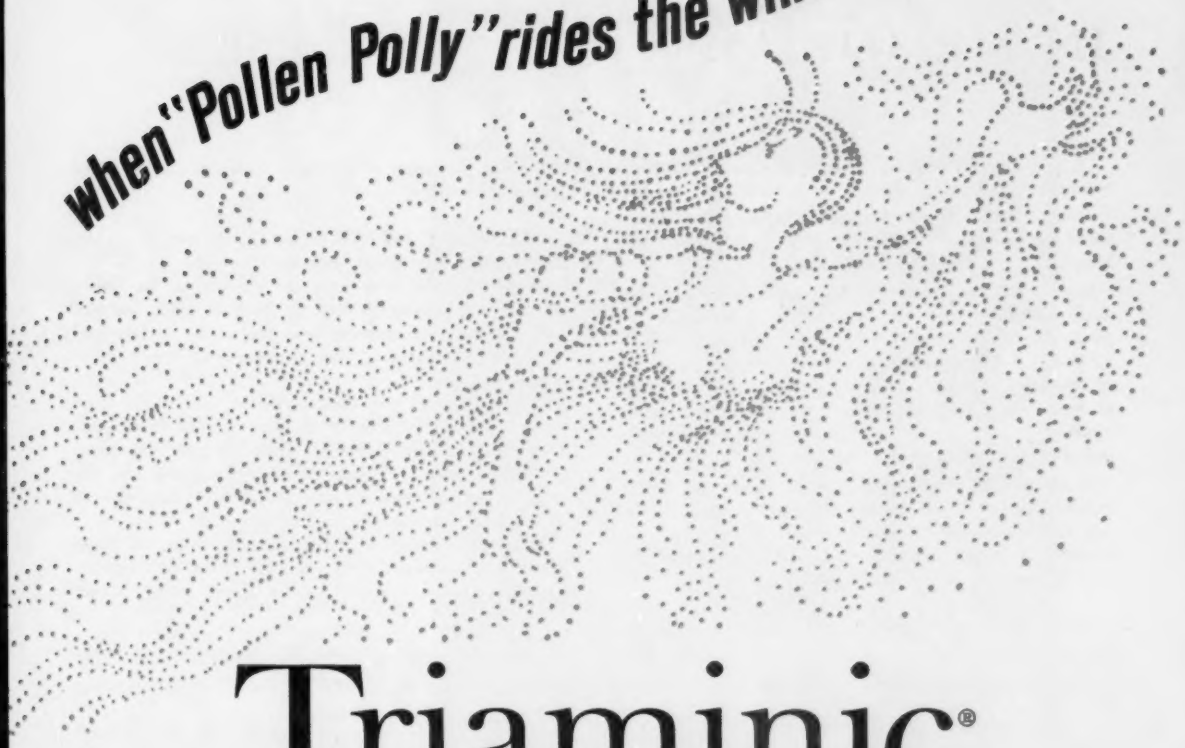
The University of Michigan Medical Center will hold a conference on "The Kidney, Its Structure and Function," June 25-26.

The program will be presented by authorities in the field from throughout the United States.

The event is under the direction of John M. Sheldon, M.D., Ann Arbor.

Sponsoring the conference is Merck Sharp & Dohme.

when "Pollen Polly" rides the wind...



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References: 1. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. 7:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy 18:36 (Jan.) 1960.

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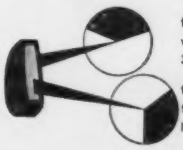

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IN MEMORIAM

V. GEORGE CHABUT, M.D., fifty-one, a practicing Northville physician for eighteen years, died April 4, 1960.

Doctor Chabut, born in Youngstown, Ohio, was a graduate of Albion college and the University of Michigan medical school.

He was currently chief of staff of Northville's Community General Hospital and was an active force in the recent re-opening of the facility. Doctor Chabut had been a member of the staff at New Grace hospital since internship 20 years ago. He was chairman of the steering committee of the Wayne County Health and Education Commission, a member of the American and Michigan Trudeau Societies and American School Health Association.

In addition to other medical affiliations, he was also a member of the Northville Rotary club, a 32nd degree Mason and member of the Northville Lodge F.&A.M. No. 186, Northville Commandery No. 39, Moslem Temple and the First Presbyterian church of Northville.

FREDERICK H. COLE, M.D., seventy-four, a Detroit urologist for more than fifty years, died April 14, 1960.

Doctor Cole was a graduate of Albion College, attended the University of Michigan and was graduated in 1908 from the Detroit College of Medicine. He did post-graduate work at the University of Berlin.

At the time of Doctor Cole's retirement three years ago, he was an associate professor at Wayne State University College of Medicine. He was chief of the urology departments of Receiving and Harper Hospitals, a consultant at Herman Kiefer and Highland Park General Hospitals and a public welfare commissioner for three years.

In 1958, Doctor Cole was honored by his colleagues when he received the Fifty-Year Award from the House of Delegates of the Michigan State Medical Society.

He was a member of the Detroit Athletic Club in addition to numerous medical affiliations.

JOHN A. FREEL, M.D., fifty-four, a native of Bay City and a practicing physician there since 1935, died April 20, 1960.

Doctor Freel was graduated from Marquette University and soon after began his Bay City practice. He was a member of St. Joseph's Church, Holy Name Society and the New York Academy of Science.

LUCILE R. GRANT, M.D., sixty-four, a Grand Rapids physician who specialized in allergies, died April 3, 1960.

Doctor Grant was born in AuSable and came to Grand Rapids as a child. She received a bachelor degree from Vassar college and a medical degree from the University of Michigan in 1924, taking postgraduate studies at the University of Chicago.

Doctor Grant was on the staff of Blodgett Memorial hospital.

She was a member of St. Marks Episcopal Cathedral and Alpha Phi sorority.

GEORGE P. GRAYBIEL, M.D., sixty-seven, a Caledonia general practitioner, died April 21, 1960.

Doctor Graybiel took over the practice of his father, Doctor Alex G. Graybiel, at his death in 1927, and had been serving his community since that date. He attended University of Michigan, where he graduated from medical school in 1925.

Doctor Graybiel was known to have one of the finest medical libraries in Western Michigan, part of it inherited from his father and augmented with the best publications since that time. He was a devoted gardener and his Caledonia flower gardens were known as a Kent County show place. He also was an avid sportsman.

He was a member of Emanuel Episcopal church, Hastings; R. C. Hathaway Lodge No. 387, F.&A.M., Caledonia and the Scottish rite and Saladin Shrine temple, Grand Rapids.

J. WINSLOW HOLCOMB, M.D., fifty-two, Grand Rapids physician for twenty-five years and life resident, died April 14, 1960.

Doctor Holcomb was a graduate of South High School, Albion College and the University of Michigan medical school.

He served as a staff physician at Blodgett Memorial and St. Mary's Hospitals. In the last three years, he retired from practice due to a heart ailment and served as health officer for the city of East Grand Rapids and as a staff physician at the Michigan Veterans facility hospital.

Doctor Holcomb was affiliated with Tau Kappa Epsilon and Phi Rho Sigma, and was a former member of Round Table of Grand Rapids and former vice president of Kent County Tuberculosis society.

DON M. HOWELL, M.D., seventy-one, a Saginaw eye, ear, nose and throat specialist since 1942, died April 2, 1960.

Doctor Howell was born in East Tawas, attended the University of Michigan medical school and Wayne State University, where he received his medical degree.

Previous to his coming to Saginaw, he had been a practicing physician in Alma for nine years and in Detroit for eleven years.

He was a member of the Elks Lodge, Masons, Saginaw Club and Saginaw Country Club.

HORACE C. JONES, M.D., sixty-one, head of the X-Ray Department at Blodgett Memorial Hospital, Grand Rapids, died April 20, 1960.

Doctor Jones, born in Arkansas, was a graduate of Arkansas college and the University of Arkansas. In World War II, he served as a captain in the navy medical corps.

(Turn to Page 966)

HORACE C. JONES, M.D.

(Continued from Page 964)

Doctor Jones was with Henry Ford Hospital in Detroit, and in 1946 became head of Blodgett X-Ray department.

Doctor Jones' numerous medical affiliations included past presidency of the Detroit Roentgen Ray Society. He was chairman of the board of elders of Calvary Baptist Church.

MORRIS H. MARKS, M.D., fifty-nine, Detroit physician, died April 17, 1960.

Doctor Marks was born in Pittsburgh, coming to Detroit in 1903. He was graduated from the University of Michigan Medical School in 1924 and the Detroit College of Law in 1937.

He was a member of Pisgah Lodge of B'nai B'rith and a past president, organizer and charter member of the Detroit chapter of the American Academy of General Practice.

He was serving as a board member of the Detroit chapter of the Michigan Association for Emotionally Disturbed Children at the time of his death.

JOSEPH E. ROSENFELD, M.D., sixty-one, Battle Creek physician and civic leader, died April 2, 1960.

Doctor Rosenfeld was one of the physicians who, in the 1930's, recognized that the lower income groups needed some type of assured medical care, and this group, eventually, resulted in the founding of the Michigan Medical Service. He was also an active leader in the local schools and was instrumental in reviving the Community Hospital project which had been halted by the depression of the 30's.

PETER E. TUYNMAN, M.D., forty-one, an assistant Wayne County medical examiner, was killed in an auto accident, April 21, 1960.

A native of Rock Valley, Iowa, Doctor Tuynman was a graduate of Creighton University. He interned and served his residency at Mt. Carmel Mercy hospital in Detroit.

Doctor Tuynman had been an assistant medical examiner from 1949 to 1953, left to go into private practice and returned to the county position last November. He headed the first-aid department at the City-County building.

LEROY J. WALLEN, M.D., fifty-six, Sault Ste. Marie eye, ear, nose and throat specialist, died March 7, 1960.

Doctor Wallen was born in Houghton, and had been a resident of Sault Ste. Marie since 1936.

He was a graduate from Wayne State Medical School in 1933. During World War II, he served in the European Theater of Operations as a captain in the medical corps.

Doctor Wallen was a member of St. Mary's Church and the Knights of Columbus.

A. S. YOUNGS, M.D., eighty-nine, a retired Kalmazoo physician and surgeon, died March 27, 1960.

Doctor Youngs was retired during the last five years, although he served in counseling and consultation. He prac-

ticed medicine in Kalamazoo from 1902 until 1955 and for two years prior to 1902 he practiced in Welston, Michigan.

He was an active civic leader.

In 1947, Doctor Youngs was honored by his colleagues, receiving the MSMS Fifty-Year Award for having practiced medicine for half a century.

Hold Second U-M Doctor's Day

The president of the Michigan State Medical Society was the honorary chairman for "Doctor's Day" at The University of Michigan in May. Milton A. Darling, M.D., Detroit, presided over the second professional Doctor's Day.

The day-long program started at 9 a.m. and included exhibits on current research activities, clinical conferences, tours of the Medical Center, and surgical demonstrations on closed-circuit color television.

John S. DeTar, M.D., Milan, addressed the group at luncheon, on the topic, "The U-M Medical Center: What the Profession Expects of It."

John R. G. Gosling, M.D., Ann Arbor, was chairman of the Doctor's Day arrangements committee.

New Professional Nutrition Society Formed

The formation of a new professional association, The American Society for Clinical Nutrition, was announced during the meetings of The American Society for Clinical Investigation and The American Federation for Clinical Research May 1, 1960. Arrangements are being made to affiliate the ASCN with the American Institute for Nutrition.

ANOTHER YEAR OF SYMPOSIA . . .

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 9th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.

ANCHORAGE, ALASKA
Saturday, June 11, 1960
The Westward Hotel

WEST POINT, NEW YORK
Thursday, Friday, Saturday,
June 16, 17, and 18, 1960
United States Thayer Hotel

***MADISON, WISCONSIN**
Thursday, June 23, 1960
The Holiday Inn

***SPRINGFIELD, MISSOURI**
Sunday, June 26, 1960
The Holiday Inn

***ROANOKE, VIRGINIA**
Saturday, July 16, 1960
The Hotel Roanoke

***SANTA ROSA, CALIFORNIA**
Friday, September 16, 1960
The Flamingo Hotel

***KANSAS CITY, KANSAS**
Friday, September 23, 1960
Battenfeld Memorial
Auditorium

HOUSTON, TEXAS
Saturday, September 24, 1960
The Shamrock Hilton Hotel

DEFIANCE, OHIO
Wed., September 28, 1960
Defiance College

PHILADELPHIA, PENN.
Sunday, October 16, 1960
The Sheraton Hotel

***HARTFORD, CONNECTICUT**
Thursday, October 20, 1960
The Statler Hotel

***GREAT FALLS, MONTANA**
Saturday, October 22, 1960
The Rainbow Hotel

ROCHESTER, NEW YORK
Wednesday, October 26, 1960
The Manger Hotel

CHARLESTON, WEST VIRGINIA
Sunday, October 30, 1960
The Daniel Boone Hotel

SIOUX FALLS, SOUTH DAKOTA
Tuesday, November 1, 1960
The Sheraton-Cataract Hotel

***CHARLOTTE, N. CAROLINA**
Thursday, November 3, 1960
The Hotel Charlotte

***CLEVELAND, OHIO**
Wednesday, November 9, 1960
Pick Carter Hotel

***SOUTH BEND, INDIANA**
Friday, November 18, 1960
The Pick-Oliver Hotel

WESTCHESTER COUNTY, N. Y.
Wednesday November 30, 1960
Westchester Country Club

ST. PETERSBURG, FLORIDA
Saturday, December 3, 1960
Tides Hotel and Bath Club

*Acceptable for Category I Credit for members of American Academy of General Practice

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

Urge Students Enter Medicine

First-hand advice and information was given to interested University of Michigan students recently at a Careers Conference at Ann Arbor.

A panel program was presented by the U-M Bureau of Occupational Information with the cooperation of the Michigan State Medical Society.

Charles J. Tupper, M.D., associate dean of the medical school, was the panel chairman. All the speakers stressed the increasing need for qualified personnel in the many medical and health fields.

The speakers included Robert S. Ideson, II, M.D., Ann Arbor, who told the need for general practitioners, Herbert D. Millard, D.D.S., dentistry; R. W. Lowe, Pharmacy; Miss Theresa Phelps, nursing; John A. Doherty, Michigan Health Council, about para-medical careers, and Doctor Tupper, who talked about the general need for more students in medicine. The panel program was one of three presented during the 1959-60 school year for the underclassmen.

HEADS WAYNE SOCIETY—David I. Sugar, M.D., was installed May 1 as the new president of the Wayne County Medical Society, succeeding Milton R. Weed, M.D. One of Doctor Sugar's first acts as president was to announce the appointment of Clarence I. Owen, M.D., as editor of the *Detroit Medical News*.

In the annual balloting, Wayne members elected Don W. McLean, M.D., as president-elect; Homer A. Howes, M.D., as secretary, and William Bromme, M.D., trustee. Section officers, geographic representatives, delegates and alternates also were chosen.

COLORFUL STORY—An interesting story is an interview printed in the Rochester, New York, *Democrat and Chronicle* on April 27. Richard D. Mudd, M.D., of Saginaw, was interviewed by Columnist Henry W. Clunes about the Lincoln assassination. Doctor Mudd's grandfather, Samuel A. Mudd, M.D., was a physician then at Bryantown, Maryland, and he gave emergency treatment to John Wilkes Booth for the leg injury Booth sustained in leaping from the Lincoln box at the Ford Theatre. Doctor Mudd knew nothing about the assassination. Three months later, Doctor Mudd was sentenced to prison for life. He served four years at the Fort Jefferson prison in the Florida Keyes until he was pardoned by President Andrew Johnson. While at Fort Jefferson, Doctor Mudd was the only doctor to care for 1,500 prisoners. In July, 1961, a monument will be erected to the memory of Samuel A. Mudd, M.D., at Fort Jefferson and the inscription will tell about his heroic services during a yellow fever epidemic at the prison in 1867.

Doctor Richard D. Mudd, who is medical director for the General Motors plant at Saginaw, enjoys reading every book he can find about the Lincoln assassination.

OFFER NEW FILM—A special preview of "MD USA" was held in Detroit May 6 by Smith Kline & French Laboratories. A new documentary film gives insights into the skill and understanding of five American physicians who practice in widely-scattered sections of the nation. The companion film, "MD International" was given the George Foster Peabody Award last year for "Outstanding contribution to international understanding."

Contributions for this "News Briefs" department are invited from individual physicians, from county societies, and from other health organizations. Please direct your contributions to the Editor.

HONORED BY MMS—E. F. Sladek, M.D., left, Traverse City, was honored recently at the regular meeting of the Grand Traverse-Leelanau-Benzie County Medical Society when he was presented with a certificate of service by Donald Pike, M.D., Traverse City, MSMS Councilor for the Ninth District. The award recognized 12 years of service by Dr. Sladek as a member of the board of directors of the Michigan Medical Service. Dr. Sladek is a former member of the MSMS House of Delegates, former MSMS Councilor 1939-47, former Chairman of The MSMS Council 1944-1947, and Past President of MSMS, 1948.

HONORED BY ACOG—Harold A. Ott, M.D., Birmingham, has been certified as a district vice chairman of the American College of Obstetricians and Gynecologists.

VETERANS ADMINISTRATION CONFERENCE—The Veterans Administration held an Area Conference on Rehabilitation in Dayton, Ohio, in April. M. K. Newman, M.D., of Detroit, presented a paper "Prescribing Practical and Realistic Rehabilitation Objectives for Total Rehabilitation." He also was chairman for an afternoon session.

DOCTORS, COACHES CONFER—More than 125 Michigan doctors of medicine, athletic directors and officials participated in the University of Michigan Athletic Injury Conference in May.

Eleven speakers from the U-M Medical Center and School of Dentistry keyed their talks to prevention and immediate identification of sports injuries. Robert A. Moore, M.D., Ann Arbor, told doctors and school officials some of the major danger signals that might show when athletes are "accident prone."

In addition to the two-day program of lectures, the group enjoyed the Wolverine spring football game.

SEEK STUDY HELP—The U. S. Department of Health, Education and Welfare seeks the cooperation of physicians in a study of eosinophilic xanthomatous granulomatosis and

(Continued on Page 972)

(Continued from Page 970)

most specifically Hand-Schuller-Christian disease. A study is being conducted by the Radiation Branch of the National Cancer Institute, Bethesda, Maryland. Physicians interested in referring patients should write Charles C. Zubrod, Clinical Director, National Cancer Institute, Bethesda 14, Maryland.

MEDICAL NEWS—It has been called to our attention that on page 438 of the March 1960 issue of THE JOURNAL, we used the trademark name RITALIN as a common name, that is without the use of capitals or an indication that it was a trade mark. The generic name for RITALIN® is "methylphenidate."

WRITE BOOK—A new book, "The Culture of the State Mental Hospital," has been written by H. Warren Dunham, Wayne University professor of sociology, and S. K. Weinberg, Roosevelt University professor, and published by the Wayne Press.

RECEIVES PLAQUE—Robert V. Bucklin, M.D., president of the Saginaw County Medical Society and pathologist at Saginaw General Hospital, was awarded a plaque on March 30 by his staff after he completed cutting the 40,000th tissue he has processed in his 13 years at the hospital. Medical technologists presented the award at a surprise ceremony.

CLERGY, DOCTORS CONFER—A conference between physicians and clergymen, aimed at bringing them into a closer partnership in meeting the needs of patients, was held April 28 at Wayne State University.

Physicians and ministers from across the state attended the afternoon and evening meeting.

TELLS BEAUMONT STORY—A sketch of the life of Dr. William Beaumont and a discussion of the Beaumont Foundation was presented by William M. LeFevre, M.D., MSMS Councilor, to members of the Muskegon Historical Society in April.

Dr. LeFevre reviewed the medical observations made by Dr. Beaumont and explained the role played by members of the Michigan State Medical Society in establishing the shrine on Mackinac Island to perpetuate the memory of Dr. Beaumont's contribution to medicine.

The Beaumont Foundation provides funds for the upkeep of the shrine and for the purchase of artifacts concurrent with the period. Dr. LeFevre is vice president of the Foundation.

MEDICAL MEETINGS U.S.A.

The Forty-Fifth Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, June 6-24, Saranac Lake, New York.

The Twenty-Sixth Annual Meeting American College of Chest Physicians, June 8-12, Miami Beach, Florida.

The Fifth Annual Meeting of the U. S. Committee of the World Medical Association, June 14, Hotel Americana, Miami Beach, Florida.

Seventh Institute on Science in Law Enforcement, June 20-25, Western Reserve University, Cleveland, Ohio, announced

by Oliver Schroeder, Jr., director of Western Reserve University Law-Medicine Center.

Two-week intensive course in Neuromuscular Diseases of Children with Special Emphasis on Cerebral Palsy, June 20 to July 1, Cook County Graduate School of Medicine, Chicago; for information, write to John J. Neal, Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois.

Seventh Annual Meeting of The Society of Nuclear Medicine, June 22-25, Stanley Hotel, Estes Park, Colorado.

The Second Annual Oregon Cancer Conference, July 7-8, Portland, Oregon; for information write Roscoe K. Miller, Executive Secretary, Oregon State Medical Society, 2164 S.W. Park Place, Portland 5, Oregon.

Ninth Annual Symposium for General Practitioners on Tuberculosis and other Pulmonary Diseases, July 11-15, Saranac Lake, New York; for information write John N. Hayes, M.D., General Chairman, Box 627, Saranac Lake, New York.

13th Annual Summer Institute on Survey Research Techniques, July 18-August 13, University of Michigan Survey Research Center, Ann Arbor; for information write Survey Research Center, University of Michigan, Ann Arbor.

14th Annual Rocky Mountain Cancer Conference, July 20-21, Denver Hilton Hotel, Denver, Colorado.

Third International Congress of Physical Medicine, August 21-26, at the Mayflower Hotel, Washington, D. C.; for information write Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Annual Otolaryngologic Assembly, September 24-30, University of Illinois College of Medicine, Department of Otolaryngology, Chicago, Illinois; for information write direct to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Eighth Congress of the Pan-Pacific Surgical Association, September 27-October 5, Honolulu, Hawaii; for information write F. J. Pinkerton, M.D., Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

American Otorhinological Society for Plastic Surgery, October 9, Conrad Hilton Hotel, Chicago.

American Medical Association Industrial Health Conference, October 10-12, Hotel Charlotte, Charlotte, North Carolina.

Clinical Conference on Gynecologic Cancer, October 21 and 22, The University of Texas M. D. Anderson Hospital and Tumor Institute, Houston, Texas.

13th Annual Conference on Electrical Techniques in Medicine and Biology, October 31-November 1-2, Sheraton-Park Hotel, Washington, D. C.

88th Annual Meeting of the American Public Health Association, October 31-November 4, Civic Auditorium, San Francisco, California.

SPEAKS IN HOLLAND—Samuel J. Levin, M.D., Detroit, delivered a paper on Gastro-Intestinal Allergy at the meeting of the International Society of Gastroenterologists at The Hague, Holland, April 24, 1960.

ON ACCP PROGRAM—Two Michigan doctors of medicine participated on the program of the 26th annual meeting of the American College of Chest Physicians at

Miami Beach, Florida, in June. Robert F. Ziegler, M.D., Detroit, was a chairman for a scientific session and he spoke about Electrocardiography in Children, and about Clinical Use of Retrograde Left Ventricular Catheterization in Congenital Heart Disease. Ellet Drake, M.D., Detroit, spoke on Diagnosis and Surgical Correction of Triatrial Heart Type B.

FTC CHARGE—The Federal Trade Commission reports that American Registry of Doctor's Nurse, 1366 National Press Building, Washington, D. C., has been charged by the Commission with misrepresenting that it is a nonprofit organization, and with giving customers the means to misrepresent themselves as registered, graduate or licensed nurses. Ralph Z. Bell, Robert L. S. and Evelyn W. Bickford, and Phillip Sellers, the concern's officials, also are cited in the FTC's complaint.

The complaint charges that their business is not a nonprofit organization of professional nurses, as implied by the trade name, but is a money-making operation conducted solely to sell insurance policies, certificates, pins, emblems and other items to persons employed in doctors' offices.

SPEAKS IN NEBRASKA—George J. Curry, M.D., Flint, was guest speaker at the 92nd Annual Session of the Nebraska State Medical Association in Lincoln, Nebraska, April 25. Doctor Curry's subjects were "Responsibility to the Injured" and "Finger Amputations."

JOINS WSU STAFF—Madeline K. Keech, M.D., an internationally-known authority on rheumatism and arthritis, has been appointed as associate professor of medicine at Wayne State University's College of Medicine. Dr. Keech will arrive from England about July 1 to teach and conduct research on the crippling diseases. Dr. Keech is presently an Empire Rheumatism Council Fellow in the department of medicine at Leeds University, England.

GRANTED LEAVE—Fred J. Hodges, M.D., professor of radiology at the University of Michigan Medical School, has been granted a sabbatical leave from July 1-December 31. He plans research in the field of image amplification and application of television techniques to radiology at selected centers in Europe and the United States.

M.D. LOCATIONS—The following report is made for April:

Assisted by Michigan Health Council

Robert L. Atkinson, M.D.....St. Joseph
Robert B. Johnson, M.D.....Ithaca

Placed by Michigan Health Council

Robert E. Stelle, M.D.....Crystal Falls

HEAR AMA OFFICIALS—The University of Michigan Conference of Affiliated Hospitals in April, heard John C. Nunemaker, M.D., AMA Council on Medical Education and Hospitals, and Wright R. Adams, M.D., AMA's American Board of Internal Medicine. John M. Sheldon, M.D., and Harry A. Towsley, M.D., were the conference program chairmen.

SPEAKER—George H. Koepke, M.D., Ann Arbor, was one of the speakers at the annual meeting of the Michigan Occupational Therapy Association in May.

MEDICAL TELEVISION SHOWS—The Michigan Health Council reports the following topics were covered during April on the weekly Sunday morning program over WJBK-TV in Detroit: Cancer, Hospital Care, Health Careers.

SUPPORT TB PROGRAM—Tuberculosis control in Michigan got a big boost in April when 40 M.D.'s and health authorities, meeting at Kellogg Center, voted to endorse major recommendations of a national conference on tuberculosis held late last year in New York. These recommendations call for intensified treatment programs using available drugs, efforts to measure tuberculosis detection programs, and expanded medical and social research.

Reports reviewed by the conference showed Michigan well ahead of many parts of the nation in its progress against tuberculosis, but the disease is still one of our most serious public health problems, according to C. J. Stringer, M.D., president of the Michigan Tuberculosis Association. The conference agreed that added impetus is needed in the program to control TB.

MINORU YAMASAKI, Detroit architect who designed the new MSMS headquarters, received an honorary Doctor of Humanities degree from Wayne State University May 4. Last year Mr. Yamasaki received first honor award from the American Institute of Architecture for design and execution of the McGregor Memorial Conference Center on the WSU campus.

DEDICATE NEW LABS—New modern research laboratories were opened in April by Parke, Davis & Company in Ann Arbor.

An estimated 1,000 joined with national, state and city officials in the ceremony which marked the opening of the new $13,500,000 laboratories. The new facility is located on a 50-acre site four miles from the center of Ann Arbor. The new buildings, of contemporary design, contain 250,800 square feet of floor space and represent a 115 per cent increase for the firm in area devoted exclusively to research and product development.

RN SCHOLARSHIPS—Three tuition grants of $1,000 each will be awarded soon by Wayne State University's College of Nursing to registered nurses. Recipients will be provided with a tuition scholarship for three years of full-time study required of graduates of hospital diploma schools to complete requirements for the Bachelor of Science in nursing degree.

OFFER LOANS—The American College of Obstetricians and Gynecologists has set up a Higher Education Loan Program (H-E-L-P) to enable resident physicians to complete their training in obstetrics and gynecology. Loans up to $5,000 will be made to help physicians through their specialty training period and early practice. For in-

formation, write to Donald F. Richardson, Executive Secretary, ACOG, 79 West Monroe Street, Chicago 3.

PARIS MEETING—The First International Congress of Histochemistry and Cytochemistry will be held in Paris August 28-September 3. Write to R. Wegmann, M.D., Congress secretary-general, Institut d' Histochimie Medicale, 45, rue des Saints-Peres, Paris, France.

HONOR GRAD—Ira D. Odle, M.D., Flint, attended the 50th year Purdue University anniversary at Lafayette, Indiana, in April, as an honored graduate of Purdue.

NATIONAL LIBRARY OF MEDICINE—Cold weather and snow conditions delayed progress on the new National Library of Medicine building during the winter but work will step up this summer.

EXAMINATION TIME—Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part I, and requests for re-examination in Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline for receipt of applications is August 1, 1960. Candidates are requested to write to Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6.

EUROPEAN SEMINARS—The American Otorhinologic Society for Plastic Surgery will hold European Seminars in Plastic Surgery of the Head and Neck in various capitals of Europe starting with departure from New York City, July 22, 1961, via chartered plane and arrival in Paris July 23, in time for the International Congress of Otolaryngologists, July 23 to July 28, 1961. Write Joseph G. Gilbert, M.D., Secretary, 75 Barberry Lane, Roslyn Heights, New York.

NEW U-M PROGRAM—The University of Michigan Medical School will launch a special studies program for about 10 per cent of the 200 students entering the Medical School this fall.

The program is an attempt to provide a more challenging medical education for the superior student. It is similar to an "Honors" program at the undergraduate level.

John M. Weller, M.D., associate professor of internal medicine, has been named co-ordinator of the program.

FELLOWSHIP PROGRAM—A fellowship program to further medical education by sending future doctors to remote areas of the world will be started this summer by the Association of American Medical Colleges.

The program will enable selected medical students to gain wide clinical experience and to assist in the continuing war against disease in the backward areas of the world.

The three-year program, established under a $180,000 grant from Smith, Kline & French Laboratories, is open to all medical college students who have completed their third year of study. The program will permit an average of 30 students to participate each year.

INVITES EXHIBITS—Application forms for space in the Scientific Exhibit at the Clinical Meeting of the American Medical Association, November 28 to December 1, Washington, D. C., are now available. Write to Charles H. Bramlitt, M.D., Director, Department of Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago 10. Applications close on August 1.

Michigan Authors

Russell N. DeJong, M.D., Ann Arbor, "The Treatment of Parkinsonism," *Connecticut Medicine,* March, 1960.

Merle Lawrence, Ph.D., Ann Arbor, "Applied Physiology of Middle Ear Sound Conduction," *AMA Archives of Otolaryngology,* February, 1960.

Harold F. Schuknecht, M.D., and **Stanley Oleksiuk, M.D.,** Detroit, "The Metal Prosthesis for Stapes Ankylosis," *AMA Archives of Otolaryngology,* February, 1960.

H. P. Doub, M.D., and **J. J. Shea, M.D.,** Detroit, "Pneumatosis Cystoides Intestinalis," *The Journal of American Medical Association,* March 19, 1960.

Andrew F. Caughey, Jr., M.D., Detroit, "Genetic Factors in the Prognosis of Rh Erythroblastosis," *Obstetrics and Gynecology,* March, 1960.

H. Saul Sugar, M.D., Detroit, "Pupillary Block in Phakic and Aphakic Eyes," *Journal of the International College of Surgeons,* March, 1960.

William N. Hubbard, Jr., M.D., Ann Arbor, "Mental Health Research in the Medical School," *The University of Michigan Medical Bulletin,* February, 1960.

John M. Weller, M.D., Ann Arbor and **Paul T. Cottier, M.D.,** Bern, Switzerland, "Clinical Evaluation of Renal Function," *The University of Michigan Medical Bulletin,* February, 1960.

Harold F. Falls, M.D. and **William J. Schull, Ph.D.,** Ann Arbor, "Hallermann-Streiff Syndrome," *A.M.A. Archives of Ophthalmology,* March, 1960.

W. O. Umiker, M.D., D. R. Korst, M.D., R. P. Cole, M.S. and **S. G. Manikas, B.S.,** Ann Arbor, "Collection of Sputum for Cytologic Examination," *The New England Journal of Medicine,* March 17, 1960.

Marion DeVault, M.D. and **H. C. Schafer, M.D.,** Detroit, "Anesthetic Management of Penetrating Wounds of the Heart," *Journal of the American Medical Association,* April 23, 1960.

Donald C. Nilsson, M.D., Nebraska, and **James C. Sisson, M.D.,** Ann Arbor, "Allergy to Penicillin," *The Nebraska State Medical Journal,* April, 1960.

Seward E. Miller, M.D., Ann Arbor, "Proposed Medical Standards for the Operators of Commercial Vehicles," *Industrial Medicine and Surgery,* April, 1960.

Jerome W. Conn, M.D., Ann Arbor, "Evolution of Primary Aldosteronism As A Highly Specific Clinical Entity," *Journal of the American Medical Association,* April 9, 1960.

Otis J. King Jr., M.D. and **W. W. Glas, M.D.,** Eloise, "Spinal Subarachnoid Hemorrhage Following Lumbar Puncture," *A.M.A. Archives of Surgery,* April, 1960.

George E. Block, M.D. and **Philip A. Zlatnik, M.D.,** Ann Arbor, "Giant Fibroadenomata of the Breast in a Prepubertal Girl," *A.M.A. Archives of Surgery,* April, 1960.

Harry M. Nelson, M.D., Esther M. Dale, M.D. and **Gerald S. Wilson, M.D.,** Ann Arbor, "Cytological Diagnosis of Uterine Cancer," *Virginia Medical Monthly,* April, 1960.

COMMUNICATIONS

Mr. William J. Burns
Executive Director
Michigan State Medical Society
Dear Bill:

Perhaps I have not been as observant as I should have lately, but I have just noticed the new typography and make-up of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY—it is most attractive.

It is one of the most attractive state journals I have seen, and for what it is worth I send along my congratulations.

Best personal regards.

Sincerely yours,
Hugh N. Jones
Director of Public Relations

Chicago, Illinois
April 19, 1960

Dear Dr. Haughey:

I just wish to congratulate you on the wonderful issue of the MICHIGAN JOURNAL dedicated to the memory of Dr. Foster. As he was such an eminent pediatrician and pioneer in this area, I wonder if a copy of this journal has been sent to the American Academy of Pediatrics at 1801 Hinman Avenue, Evanston, Illinois. I am sure they would be very grateful to receive it.

Yours very truly,
ROBERT M. HEAVENRICH, M.D.

Saginaw, Michigan
May 3, 1960

* * *

EDITOR: The answer is "yes." Thank you.

WSU Graduates 63

Sixty-three students were graduated by the Wayne State University College of Medicine at the annual commencement June 16 at the State Fair Coliseum. A total of 1,530 June graduates received their Wayne diplomas, after brief comments by President Clarence B. Hilberry and others.

EDITORIAL COMMENT

Answering the Critics with Facts

(Progress in Health Services Publication, May, 1960)

Hospitals and the medical profession are being criticized for unnecessary admission of patients for treatment in general hospitals. Many patients, it has been suggested, might be cared for more economically in nursing homes or treated at less expense in other ways.

Such criticisms can be resolved only as we learn more about present utilization and charges in general hospitals. Criticism that proves valid obviously calls for correction, but unfair criticism only confuses attempts to provide better service. This analysis of Blue Cross subscribers in Indiana is the type of information needed in the planning of high-quality, economical services.

The data analyzed here give little support to the criticism that great numbers of patients are unnecessarily admitted to general hospitals or could be treated less expensively elsewhere. This finding has nationwide implications: While the 843,046 Blue Cross subscribers in Indiana are not an exact cross-section of the population in their state or for the country as a whole, the group is large enough to furnish some measure of the diagnoses causing admission to general hospitals, length of stay, and costs of care. Furthermore, hospital costs in Indiana appear to be close to national averages.

(See "Indiana Study Shows Most . . .," Page 874)

The cost of general hospital care, spread over the total Blue Cross population in Indiana, comes to $19.22 per person per year; of this amount, $11.99 is for surgical patients. The major diagnostic category accounting for the greatest proportion of hospital days and charges per person annually is digestive diseases; most patients in this category, incidentally, are treated surgically. It is no accident that these high-cost services are ones through which recent reductions in mortality have been especially striking. The present cost, while substantial, is in part the price of progress.

Childbirth in the hospital also takes up a large share of the Blue Cross dollar, mainly because almost all births today occur in hospitals against only 37 per cent in 1935. The reduction in infant and maternal mortality supports the value of new medical knowledge applied within the hospital.

Within its limitations, this study provides valuable data; it also demonstrates how more adequate statistics can be helpful in improving services. Voluntary health insurance agencies could supply more such data for national planning.

Medical Prepayment and Our Social Philosophy

Blue Shield Medical Care Plans, Inc.

"A curious paradox of some contemporary social philosophy is the idea that man should spend what he earns for his pleasures rather than for what he needs. It is appropriate, so this reasoning goes, that he should buy a television set, a vacation in Florida or an outboard motor boat, because these are cardinal rights. But for something that he really needs, such as his life or his health, or the life of his child, someone else should pay. This may be the Government, his employer, his union, his great-aunt or anyone else who can be cajoled or coerced into paying the price for him. If no one else will pay for it, the doctor should serve him for nothing."

This observation by C. Marshall Lee, Jr., M.D., Boston, raises a question of crucial importance not only to the medical economy but to the whole pattern of our American society. (Dr. Lee comments on these matters in the February issue of the *New England Journal of Medicine.*)

For, as Dr. Lee puts it, the attitude he describes "may be acceptable for the child of an indulgent parent, but it is not appropriate for a free man in a free society."

What can the doctor do to counteract this philosophy and to forestall the socialization of medicine which may be its ultimate product?

First, the doctor should learn all he can learn about our voluntary medical prepayment programs. Physicians should recognize that, in Dr. Lee's words, "Far from being the meddlesome 'third party' for which they have an uneasy fear, (the prepayment program) stands with them in the common effort to preserve a cherished concept of freedom."

Secondly, the doctor—and only he—can make these programs operate to the satisfaction of the patient. Only he can see to it that the subscriber gets full value for the premium dollar he has invested in our voluntary medical care program.

Finally, the medical profession's own sponsored Blue Shield Plans offer the American doctor an opportunity not only to strengthen and confirm his patient's confidence in our traditional way of practicing medicine, but also to participate actively in guiding the destiny of our medical prepayment program in the days ahead.

The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

WORTH QUOTING

"The purpose of the medical reader is to broaden his view, not merely to find a simplified set of rules for earning his bread and butter."—JOSEPH GARLAND, M.D., Editor, *New England Journal of Medicine.*

X-RAY TECHNOLOGY. By Charles A. Jacobi, B.Sc., R.T. (A.R.X.T.), M.T. (A.S.C.P.), Chairman, Medical X-Ray Technology, Oregon Technical Institute, Oretech Branch, Klamath Falls, Oregon; Chairman, Education Committee, Oregon Society of X-Ray Technicians; Chairman, Education Committee, Northwest Conference of X-Ray Technicians; formerly Chief X-Ray and Medical Technologist, Medical Services Division, Atomic Energy Commission, National Reactor Testing Station, Idaho Falls, Idaho and Donald E. Hagen, R.T. (A.R.X.T.), Technical Supervisor for C. Todd Jessell, M.D., and George R. Satterwhite, M.D., Radiologists, Portland, Oregon; Formerly Instructor, Medical X-Ray Technology, Oregon Technical Institute, Oretech Branch, Klamath Falls, Oregon. Second edition. 320 Illustrations. St. Louis: The C. V. Mosby Company, 1960. Price, $10.00.

It is obvious to the reviewer that x-ray technicians will appreciate this revised second edition. The addition of forty-three pages has not spoiled the simplicity and ready graspability of subject matter, which is all important in this type of text.

The contents have been brought up to date and the first seven chapters have been revised to facilitate teaching of fundamental principles. These points are significant, particularly in the x-ray field where automation constantly plods forward.

The book is a good text with emphasis on teaching of standard procedures and practical x-ray technology. The style of writing is clear and the book contents easy to follow. Glossary and Index appear adequate.

Those who use this text will appreciate the paper, printing and structure that the publishers have built into it. The price is fitting.

R.C.H.

PATHOLOGY OF THE HEART. Edited by S. E. Gould, M.D., D.Sc. Professor of Pathology, Wayne State University College of Medicine. Professor of Pathology, University of Detroit School of Dentistry, Detroit, Michigan. Director of Pathology, Wayne County General Hospital, Eloise, Michigan. Research Associate and Lecturer in Pathology, University of Michigan School of Medicine, Ann Arbor, Michigan. With a Foreword by Howard T. Karsner, M.D. Second Edition. Springfield, Illinois: Charles C Thomas, 1960. Price, $32.50.

Pathology of the Heart is a completely re-edited and re-set second edition of a widely acclaimed work under the editorship of Dr. Gould of Wayne University.

This group of twenty able authors has again produced an outstanding work which is devoted exclusively to the pathology of the heart and is the only such work of this scope that I know of, at least in current publication. It deals with carefully documented, clearly presented, up-to-date material and is written in a lucid, readily understandable style which is a pleasure to read.

An interesting chapter on clinicopathologic correlations is included by Dr. Gordon Myers.

Five new chapters have been added to the first edition: The Conduction System, Diseases of the Aorta, Cardiopulmonary Disease, Surgery of the Heart, and Histochemical Study of the Heart. The avowed objectives of providing current authoritative material in readily understandable terms, with a practical approach to clinical correlation has been more than amply accomplished.

The text is well illustrated and beautifully printed and, though expensive, should be enthusiastically received. It is heartily recommended to all those with more than casual interest in the subject, to clinician and pathologist alike.

R.W.B.

THE ACUTE MEDICAL SYNDROMES AND EMERGENCIES. Diagnosis and Treatment. By Albert Salisbury Hyman, M.D., Associate Clinical Professor of Medicine, New York Medical College, New York, N. Y. With the Collaboration of Samuel Weiss, M.D., Professor of Gastroenterology Emeritus, New York Polyclinic Medical School, New York, N. Y.; George Guttman Ornstein, M.D., Associate Clinical Professor of Medicine, New York Medical College, New York N. Y.; Howard F. Root, M.D., Medical Director, Joslin Clinic, Boston, Massachusetts; Anna Ruth Spiegelman, M.D., Assistant Professor Clinical Medicine, New York University Postgraduate Medical School, New York, N. Y.; Jack Abry, M.D., Associate Attending Physician, New York City Hospital, Elmhurst, N. Y. 422 pages. New York: 1959. Landsberger Medical Books, Inc. Price, $8.75.

This small volume of 422 pages, plus an adequate index, is intended as a quick reference book. Nearly one half of the volume (186 pages), is devoted to cardiovascular emergencies. Gastrointestinal, pulmonary, diabetic and renal emergencies plus seven pages on barbiturate intoxication complete the book.

Problems of diagnosis are well and quite completely discussed. Insufficient attention has been paid to therapeutics. For instance, in discussing anti-coagulants in myocardial infarction, the pros and cons are given. The drugs are listed, but the dosage is not given. The omission of dosage might necessitate reference to a second volume should a physician feel it necessary to consult a book as to the advisability of giving anti-coagulant therapy.

This was not intended as a pocket-size or bag-size edition; the size need not have been limited. In my opinion, while the addition of adequate therapeutic discussions would have increased the size of the book, it would also have increased its value to the physician.

L.P.S.

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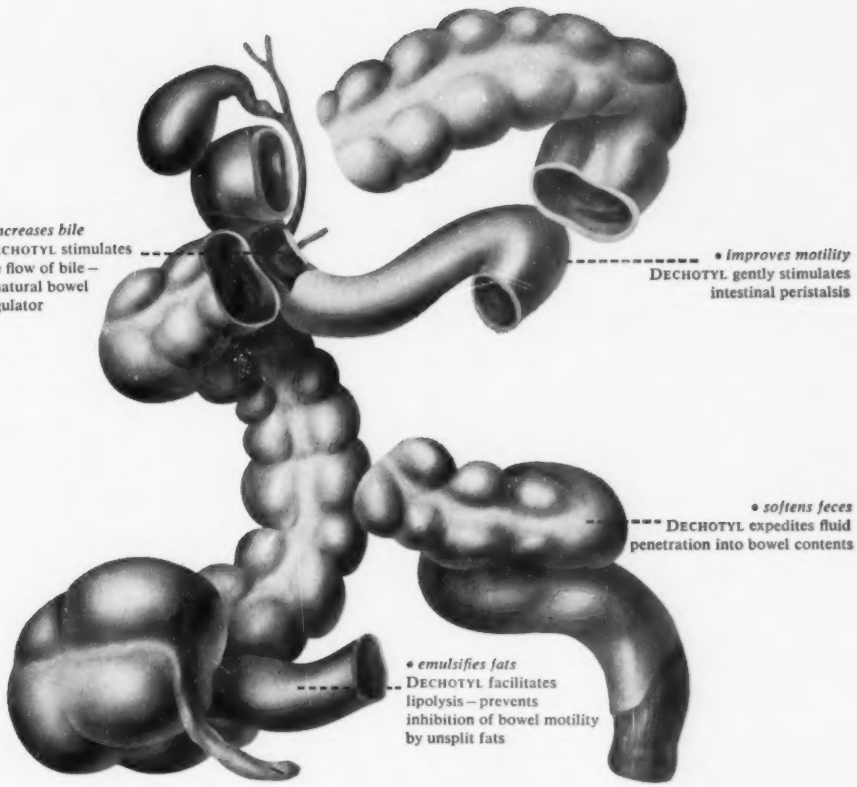

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